County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

July 31, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

LOS ANGELES COUNTY HOMELESS PREVENTION INITIATIVE STATUS REPORT

According to the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County has the highest concentration of homelessness in the nation (74,000 people). Various social and economic factors, as well as gaps in available housing and social services have contributed to the crisis. In response to this crisis, on April 4, 2006, the Los Angeles County Board of Supervisors made an investment toward addressing and preventing homelessness with the approval of the $100 million Homeless Prevention Initiative (HPI). The Chief Executive Office continues to implement specific key HPI programs in partnership with County Departments of Children and Family Services, Community Development Commission, Health Services, Mental Health, Probation, Public Defender, Public Health, Public Social Services, the Sheriff, LAHSA, and various cities. Through March 2009, the HPI has been tremendously successful in implementing 27 programs and serving over 25,000 individuals and 12,000 families (some programs may serve the same participants). The initiative focuses on reaching the following two goals through the six strategies shown below:

Goal 1 – Preventing Homelessness

- Housing assistance
- Transitional supportive services

Goal 2 – Reducing Homelessness

- Community capacity building
- Regional planning
- Supportive services integration linked to housing
- Innovative program design

Three attachments are included with this memo:

1. Executive Summary of Fiscal Year (FY) 2008-09, Third Quarter;

2. HPI Status Report (Attachment A): The FY 2008-09 Third Quarter HPI status report includes information on program participants, services provided, and associated outcomes; and

3. Index of Programs (Attachment B): A table presents key performance indicators and budget information on each program. Following the table, each program's performance measures are included with a description of successes, challenges, an action plan, and a client success story.

This HPI report provides information about the progress of your Board's investment to decrease homelessness and inform future planning efforts. If you have any questions, please contact me or your staff may contact Vani Dandillaya at (213) 974-4190, or via e-mail at vkumar@ceo.lacounty.gov.

WTF:MS:KH
VKD:hn

Attachments (3)

c: Sheriff's Department
Department of Children and Family Services
Department of Community Development Commission
Department of Health Services
Department of Mental Health
Probation Department
Department of Public Defender
Department of Public Health
Department of Public Social Services
City of Santa Monica
Los Angeles Homeless Services Authority
Public Counsel
Skid Row Housing Trust

Los Angeles County
HOMELESS PREVENTION INITIATIVE (HPI)

FY 2008-09, JANUARY – MARCH, THIRD QUARTER EXECUTIVE SUMMARY

Left: HPI funding expanded supportive services provided by A Community of Friends at AMISTAD Apartments, a mixed population building in Lincoln Heights. AMISTAD Apartments consists of low-income families and special needs families; *Right:* A Los Angeles County Homeless Court participant receives his graduation certificate from Judge Michael Tynan.

MAXIMIZING OPPORTUNITIES TO PROMOTE SAFE AND STABLE HOUSING

As a result of the economic downturn and the County's unemployment rate exceeding 11%, more residents are at-risk of losing their homes and struggling to meet basic needs. However, many residents in need of public assistance for the first time are not eligible, because they are at or below 50% Area Median Income (AMI) (between $16,452 and $39,650 for a family of four; below $27,750 for individuals). For instance, County food stamp denials were up 14% and denials for General Relief (GR) increased by 10% compared to the same time last February. Likewise, LAHSA reported an 87% increase in families requesting shelter over the winter months compared to the previous year. Combined with the impact of the economic recession on the County's budget, finding available resources to serve those who rely on the County has become increasingly more difficult.

In response to the current economic slowdown, President Barack Obama signed the American Recovery and Reinvestment Act (ARRA) into law on February 17, 2009. Thirty ARRA grants totaling an investment of over $524 million will be allocated to the County for social services. The ARRA funding presents an opportunity to examine how the County can more efficiently support individuals and families to maintain self-sufficiency. Through $12.1 million from the ARRA Homelessness Prevention and Rapid Re-Housing Program, the County plans to provide residents with financial assistance, housing stabilization and relocation services.

In addition, the County's FY 2009-10 Homeless Service Integration Plan aligns efforts to more effectively use resources and achieve better outcomes. Focusing on a regional approach, the Plan includes expansion of successful *Housing First* models, greater access to integrated health and social services, and support for pathways to stable housing for the homeless GR population.

The HPI has served over 25,000 individuals and 12,000 families. For each strategy, specific outcomes and a combined total of actual and estimated expenditures are listed. For both the Housing Assistance and Supportive Services Integration and Linkages to Housing strategies, cumulative results are shown.

GOAL 1: PREVENTING HOMELESSNESS

HOUSING ASSISTANCE
$9,622,540

Eviction Prevention
Moving Assistance
Rental Subsidy

Through housing assistance, individuals, youth, and families maintain permanent housing.

- **3,703 individuals and 8,594 families received housing assistance, which prevented homelessness.**

Note: A participant who received more than one type of housing assistance was counted once.

TRANSITIONAL SUPPORTIVE SERVICES
$7,381,343

Access to Housing for Health
Homeless Release Projects
Just In-Reach Program
Recuperative Care

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

- **2,956 clients received public benefits.**
- **82 clients placed into permanent housing.**
- **92% decrease in inpatient days and 81% decrease in ER visits a year post enrollment.**

GOAL 2: REDUCING HOMELESSNESS

COMMUNITY CAPACITY BUILDING
$25,644,929

City and Community Program (CCP)
Revolving Loan Fund

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

- **2,360 individuals and 303 families received 4,840 linkages to supportive services and 251 housing placements.**

REGIONAL PLANNING
$3,250,000

Homeless Services
Long Beach Homeless Veterans

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

- **Gateway and San Gabriel Valley Council of Governments (COG) presented regional plans to include 1,253 units of permanent housing.**

SUPPORTIVE SERVICES INTEGRATION AND LINKAGES TO HOUSING
$11,505,541

Case Management
Housing Locators
Multi-disciplinary Team/Access Center

Provide clients with integrated supportive services and housing. Supportive services include case management, health care, mental health services, and substance abuse treatment.

- **9,771 individuals and 3,505 families placed into emergency, transitional, and permanent supportive housing.**
- **15,159 linkages to integrated supportive services enhanced participants' well-being.**
- **6,703 individuals and families achieved greater self-sufficiency through public benefits, income support, and connections to employment opportunities.**

INNOVATIVE PROGRAM DESIGN
$17,569,753

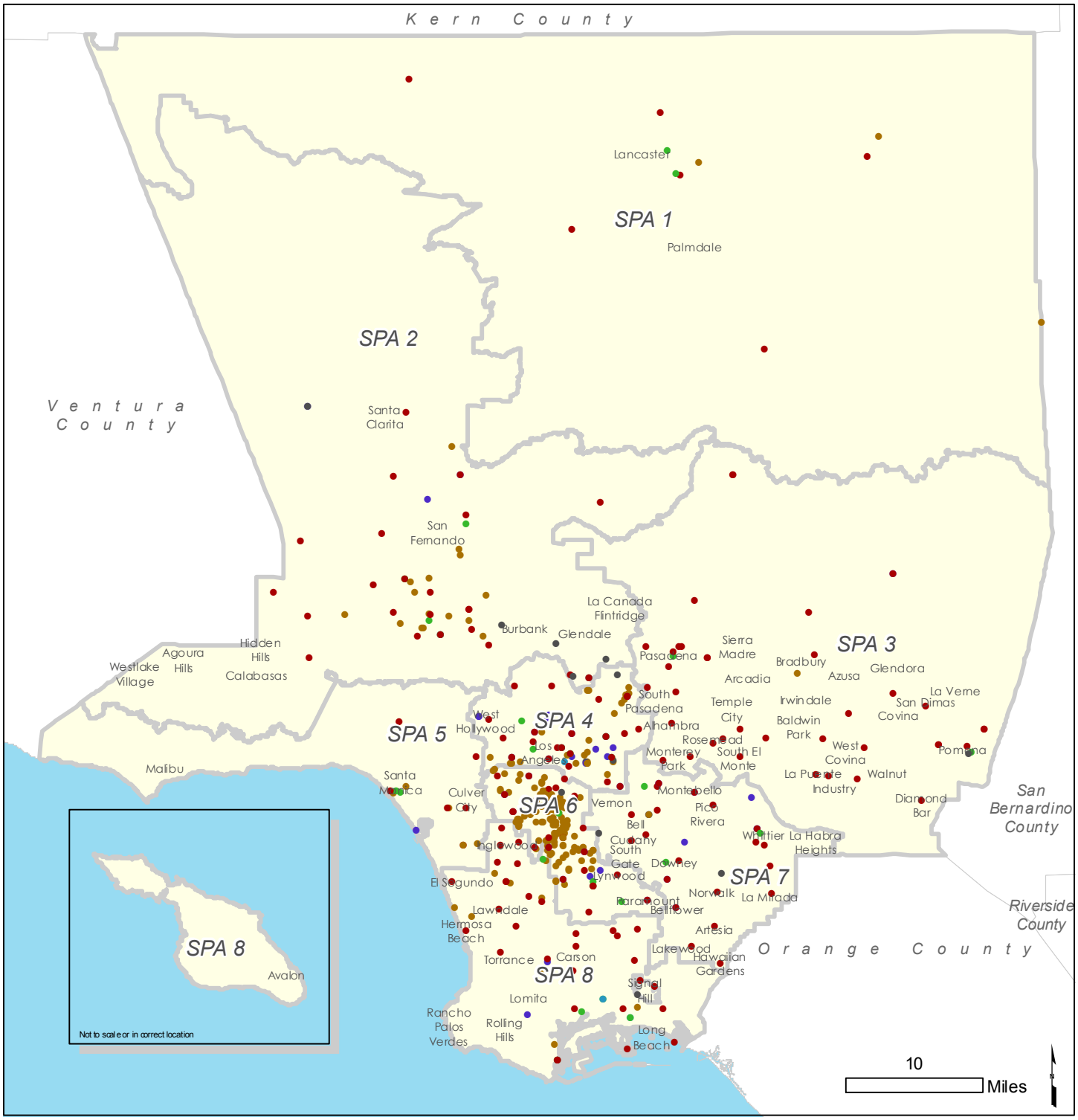
Project 50
Skid Row Families Demonstration Project
Homeless Court
Housing Resource Center
Santa Monica Service Registry

Provide access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

- **53 chronic homeless individuals placed into permanent supportive housing.**
- **237 Skid Row families placed into permanent rental housing.**
- **Citations and warrants dismissed for 877 individuals.**
- **Over 2.4 million housing searches conducted.**

County of Los Angeles Regional Homeless Prevention Initiative

Housing Placement and Service Locations by Service Planning Area (SPA)



Strategy

- 1 - Housing Assistance
- 2 - Transitional Supportive Services
- 3 - Community Capacity Building
- 4 - Regional Planning
- 5 - Supportive Services Integration and Linkages to Housing
- 6 - Innovative Program Design

Notes:

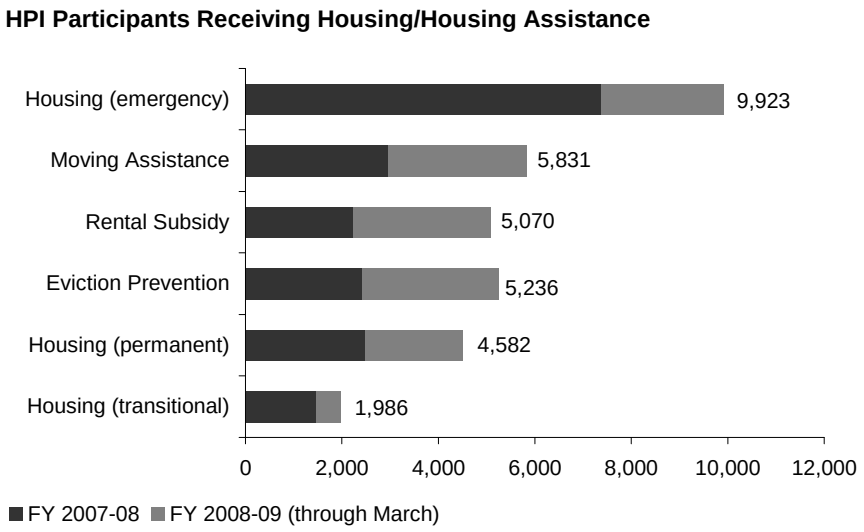
i) The following HPI programs are offered Countywide:
General Relief Housing Subsidy and Case Management Project
Los Angeles County Homeless Court
Los Angeles County Housing Resource Center
Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program
Project Homeless Connect

ii) Strategy 4 - Regional Planning includes San Gabriel Valley Council of Government Plan and Gateway Cities Homeless Strategy.

iii) Rental subsidies were provided to transition age youth who moved to cities in other counties, including: San Bernardino, Riverside, Kern, Orange, San Diego, Ventura, and Santa Barbara.

Map created by ISD/UR-GIS YM (562-940-2181) on 2009-05-14, HPI.mxd
Data from CEO/SIB, LACoeGIS Repository, and Thomas Bros Data.

It is the County's goal to work with community partners to further reduce and prevent homelessness. The chart below shows the number of HPI participants who received housing and financial assistance through March 2009.



Information about the County of Los Angeles Homeless Prevention Initiative

The Los Angeles County Board of Supervisors invested resources to address and prevent homelessness with the approval of the $100 million Homeless Prevention Initiative (HPI). The Chief Executive Office (CEO) continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), Community Development Commission (CDC), and various cities. To date, the HPI has been tremendously successful in implementing 27 programs and serving over 25,000 individuals and 12,000 families. The initiative focuses on reaching the following two goals through six strategies shown below:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Transitional supportive services
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

For additional information, please contact Vani Dandillaya at vkumar@ceo.lacounty.gov.

COUNTY OF LOS ANGELES

Homeless Prevention Initiative (HPI)
FY 2008-09, Third Quarter Status Report

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HOMELESS PREVENTION INITIATIVE (HPI) STATUS REPORT
FY 2008-09, Third Quarter

I. INTRODUCTION

In accordance with your Board's direction on April 4, 2006, this report provides a status update on the implementation of 27 programs included in the Los Angeles County Homeless Prevention Initiative (HPI) during January-March of FY 2008-09. The Chief Executive Office (CEO) continues to implement specific key HPI programs in participation with the Community Development Commission (CDC), the Departments of Children and Family Services (DCFS), Health Services (DHS), Public Health (DPH), Mental Health (DMH), Public Social Services (DPSS), Probation, Public Defender, and the Sheriff. Representatives from these County agencies, departments, and several partner organizations meet frequently to ensure consistent communication and integration of services and facilitate successful implementation of HPI programs serving the County's homeless population.

HPI funding has allowed for greater access to housing and supportive services for the homeless and at-risk population. This HPI status update highlights results achieved through program strategies that have served over 25,000 individuals and 12,000 families.[1] This report features components of the HPI, associated outcomes, and opportunities to further enhance and integrate the network of providers.

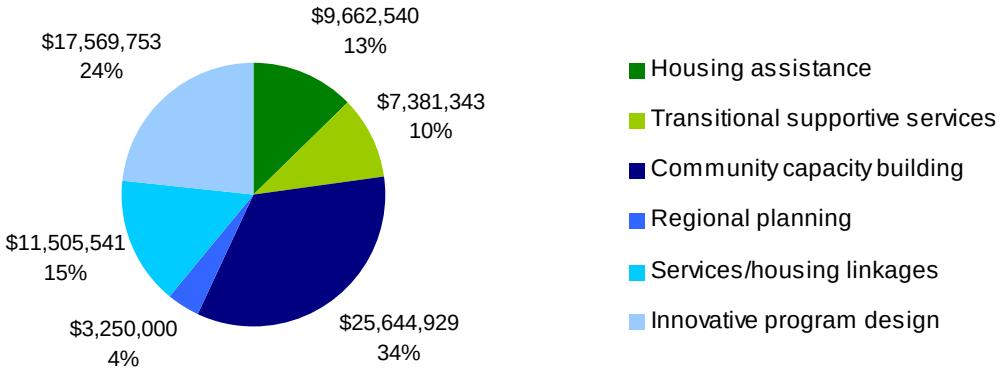
Goals and Strategies

As mentioned in the Executive Summary, the CEO continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), CDC, and various cities. The initiative focuses on meeting the following two goals through six strategies shown:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Transitional supportive services
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

[1] Currently, a standardized data system is not in place to determine if any client is shared across programs, therefore, the total number of participants may include a duplicate count.

Chart 1: Estimated Actual Expenditures
Total: $75,014,106*



*Actual expenditures are approximately $78.3 million. Additional expenditures include: 1) Board approved operational support at $1.9 million (FY 2006-07); and 2) operational support, administrative, and evaluation costs at approximately $1.4 million. *From upper right (clockwise) beginning with Housing Assistance.*

Actual and Estimated Expenditures by Strategy

In this report, total expenditures include FYs 2006-07 and 2007-08 actual expenditures and estimated expenditures for FY 2008-09. The total expenditures for the HPI programs in this report are $74,974,106. Chart I shows that 23 percent of all expenditures have or will be spent on the initiative's first goal to prevent homelessness. Seventy-seven percent of all expenditures have or will be spent on the HPI's second goal to reduce homelessness. In addition, the amount expended by each strategy is shown in Chart I. For the community capacity building strategy, 34 percent of all expenditures are designated for housing development and supportive services in 21 communities via contracts with local housing developers and service providers.

Maximizing Opportunities to Promote Safe and Stable Housing

In response to the current economic slowdown, President Barack Obama signed the American Recovery and Reinvestment Act (ARRA) into law on February 17, 2009. Thirty ARRA grants totaling an investment of over $524 million will be allocated to the County for social services. The ARRA funding presents an opportunity to examine how the County can more efficiently support individuals and families to maintain self-sufficiency. Through $12.1 million from the ARRA Homelessness Prevention and Rapid Re-Housing Program (HPRP), the County plans to provide residents with financial assistance, housing stabilization and relocation services. In June 2009, the U.S. Department of Housing and Urban Development approved the County's HPRP application, and the County is to receive a grant agreement in August. Currently, County departments are working with CDC and LAHSA to be ready for implementation in October.

In addition, the County's FY 2009-10 Homeless Service Integration Plan aligns efforts to more effectively use resources and achieve better outcomes. Focusing on a regional approach, the Plan includes expansion of successful *Housing First* models, greater access to integrated health and social services, and support for pathways to stable housing for the homeless GR population.

This report provides an overview of HPI participants, the initiative's six strategies and associated outcomes, and opportunities to strengthen the overall system of homeless services.

II. PARTICIPANTS

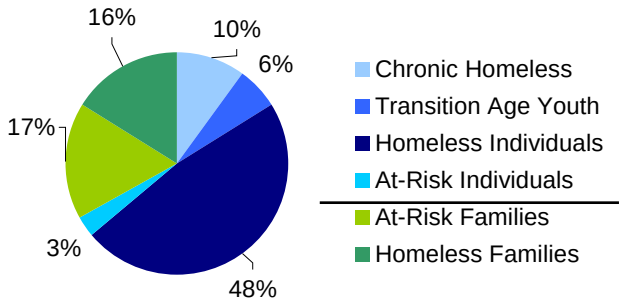
During the third quarter of FY 2008-09, 24 of 27 implemented HPI programs[2] directly served the County's homeless and nearly homeless. While several programs served more than one population, participants in 19 programs corresponded to one of five categories: homeless individuals (seven programs), chronic homeless individuals (four programs), transition age youth (two programs), homeless families (three programs), and at-risk families (two programs). Appendix B provides an overview of programs. To date, Table 1 shows HPI improved the lives of 25,155 individuals and 12,075 families.[3] From the second to third quarter, the number of families and individuals served increased by 17 and 16 percent, respectively. With a 44 percent increase, the proportion of at-risk individuals who were served showed the most change.

Table 1: Number of Contacts by Participant Category
FY 2008-09 Year to Date through Third Quarter (March 2009)

	FY 2008-09* Year to Date	FY 2007-08	Cumulative	Third Qtr. Increase
Homeless Individuals	5,835	12,204	18,039	12%
Chronic Homeless Individuals	1,406	2,440	3,846	19%
Transition Age Youth	986	1,121	2,107	32%
At-Risk Individuals	1,163	-	1,163	44%
Total for Individuals	9,390	15,765	25,155	16%
Homeless Families	1,839	3,946	5,785	10%
At-Risk Homeless Families	3,803	2,487	6,290	24%
Total for Families	5,642	6,433	12,075	17%
Total	**15,032**	**22,198**	**37,230**	**16%**

*FY 2008-09: Returning participants from FY 2007-08 have been subtracted for an unduplicated count.

Chart 2: Percent by Participant Category



From upper right (clockwise) beginning with Chronic Homeless.

Chart 2 illustrates that of HPI participants, 67 percent were individuals and 33 percent were families. According to LAHSA, 24 percent of the total homeless population lives in families,[4] and homeless families made up 16 percent of all HPI participants. Of all individuals, 48 percent were homeless adults, and six percent were transition age youth. Approximately one-third of the homeless in the County are chronically homeless,[5] while these individuals made up 10 percent of all participants.

[2] While Housing Locator and Housing Specialists programs are included, these programs are funded by CalWORKs Single Allocation and DMH Mental Health Services Act (MHSA), respectively. City and Community Program includes 21 separate programs.
[3] Note most programs provided an unduplicated participant number; however, four programs included a duplicated participant count during FY 2007-08. Housing Locators/Housing Specialists are included in total participant count.
[4] LAHSA 2007 Greater Los Angeles Homeless Count.
[5] Ibid.

Participant Characteristics

During the third quarter of FY 2008-09, all 24 programs provided demographic information for program participants. Demographic information included gender, age, and race/ethnicity of participants. To obtain data on HPI participants, demographic information from new participants served during this past quarter was included. Gender information from LAHSA contracted programs was added from FYs 2007-08 and 2008-09. Due to different categorization for race/ethnicity and age, these statistics for LAHSA contracted programs are shown separately in Attachment B.

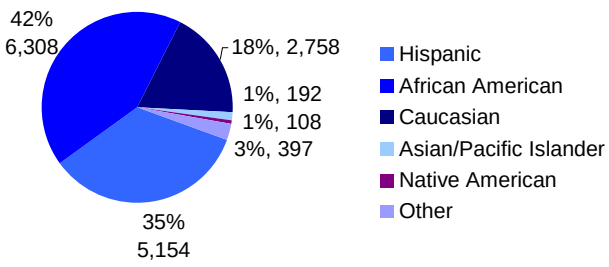
Gender

Approximately 59 percent of the homeless population in Los Angeles County consists of adult men.[6] Of the 21,990 participants whose gender was provided, 56 percent (12,275) were male and 44 percent (9,694) were female.

Race/Ethnicity

The total homeless population in Los Angeles County is about 55 percent African American and 19 percent Caucasian. Chart 3 shows 42 percent of HPI participants were African American and 18 percent Caucasian. Representing the total homeless population, 35 percent of participants were Hispanic. The remaining five percent of participants included Asian/Pacific Islander, Native American, and other racial/ethnic groups.

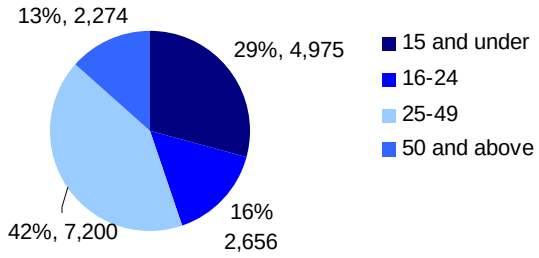
Chart 3: Race of HPI Participants (n=14,917)



Age

Compared to an average age of 45 years for homeless individuals in the County, 42 percent were between 25-49 years of age. Chart 4 shows that of HPI participants whose age was provided, 29 percent were children less than 15 years of age, 16 percent of participants were between the ages of 16-24, and 13 percent were 50 years of age and older.

Chart 4: Age of HPI Participants (n=17,105)



[6] LAHSA 2007 Greater Los Angeles Homeless Count.

III. GOALS, STRATEGIES, AND OUTCOMES

Goal I: Preventing Homelessness

Strategy ❶ Housing Assistance $9,622,540

Through housing assistance, individuals, youth, and families maintain permanent housing.

Eviction Prevention • Moving Assistance • Rental Subsidy

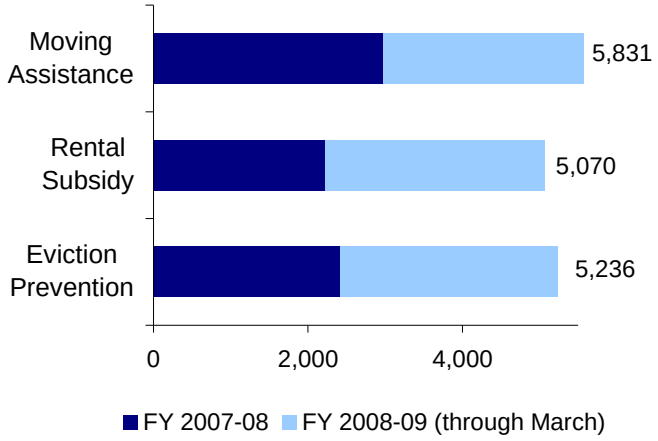
HPI programs provided housing assistance through moving assistance, eviction prevention, and rental subsidies; five programs focused on these services. ***Through March 2009, a total of 12,297 participants received housing assistance to secure permanent housing and prevent homelessness.*** Table 2 shows 69 percent of participants who obtained housing assistance were families, 23 percent were individuals, and eight percent were transition age youth. Table 2 illustrates that a greater proportion of individuals and transition age youth received rental subsidies, whereas significantly more families received eviction prevention. A participant who received more than one type of housing assistance was counted once. Chart 5 shows the number of participants who received each type of housing assistance through March 2009.

The County's HPRP plan will invest into housing assistance to prevent homelessness for families and individuals, including seniors and veterans. The Departments of Public Social Services, Children and Family Services, and Community and Senior Services will provide financial assistance for eviction prevention, moving assistance, and rental subsidies.

Table 2: Through March 2009	Housing Assistance		Moving Assistance	Rental Subsidy	Eviction Prevention
Individuals	2,780	23%	2,151	3,970	24
Transition Age Youth	923	8%	525	835	1
Families	8,594	69%	3,154	257	5,210
Total	**12,297**	**100%**	**5,830**	**5,062**	**5,235**

The following ten participants were not included in Table 2: a participant who received moving assistance, one who received eviction prevention, and eight who received rental subsidies.

Chart 5: HPI Participants Receiving Housing Assistance



Strategy ❷ Transitional Supportive Services $7,381,343

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

Access to Housing for Health (AHH) • Recuperative Care • Homeless Release Projects (DPSS-DHS and DPSS-Sheriff) • Just In-Reach Program

Discharge Planning for Hospital Patients

The Access to Housing for Health (AHH), Recuperative Care, and DPSS-DHS Homeless Release programs provided discharge planning for hospital patients at-risk of becoming homeless. A discharge plan connected these patients to needed services that helped them attain stable housing and a better quality of life. Both the AHH and Recuperative Care programs have shown improvements in health outcomes, such as reductions in Emergency Room (ER) visits and inpatient hospitalizations. These reductions lead to cost savings for the County.

Outcomes

- ***Improved Health***: Since March 2007, 41 AHH clients reached their one-year mark. They had a combined total of 183 ER visits during the 12 months prior to enrollment. Post enrollment, the clients only had a combined total of 34 ER visits for an 81% reduction. The 41 AHH clients were hospitalized for a combined total of 340 days prior to AHH enrollment. These same clients only had 28 inpatient days post AHH enrollment. The number of inpatient days was reduced by 92%.
- A six month pre/post analysis for Recuperative Care patients reported a 33% reduction in ER visits and a 67% reduction in inpatient hospitalizations.
- ***Linkages to Public Benefits***: The AHH, Recuperative Care, and DHS-DPSS Homeless Release projects made 534 connections to public benefits for individuals, including: SSI/SSDI, Medi-Cal, and General Relief.
- ***Housing Stability***: AHH placed 53 individuals into permanent housing. All 46 individuals who have been placed into permanent housing for six months or more have remained in housing.

Discharge Planning for Individuals Released from Jails

The Just In-Reach and DPSS-Sheriff Homeless Release projects connected individuals to services and benefits prior to release from jail to help support steps towards building a better future, including stable housing and employment.

Outcomes

- ***Linkages to Public Benefits***: The Just In-Reach and DPSS-Sheriff Homeless Release projects have served 4,386 individuals and made 2,422 connections to public benefits, including: General Relief, Food Stamps, SSI/SSDI, and Veteran's benefits.
- ***Housing Placement***: Housing locators have assisted 292 individuals with housing placement. The majority of housing has been emergency and transitional housing. Through the Just In-Reach program, over 103 clients identified as homeless or chronically homeless have been released to housing, transitional living or a residential program. These are clients that if not for this program, would have otherwise ended up homeless on the streets. Out of the 362 individuals enrolled, this is a 28% placement rate which is extremely high for this population.
- ***Transition to Communities:*** By offering case management to all Just In-Reach clients and focusing on education/job opportunities, 217 individuals received job related/education services, and 83 percent (223 of 270 who remained in the program) have not returned to jail.

Goal 2: Reducing Homelessness

Strategy ❸ Community Capacity Building $25,644,929

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

City and Community Program (CCP) • Revolving Loan Fund

City and Community Program (CCP)

- To date, ten programs served 2,360 individuals and 303 families. They made ***4,840 linkages to supportive services and 251 housing placements***. Fourteen of 15 service contracts were executed.
- The State's current inability to fund previously committed loans has brought a number of developments that include HPI, City of Industry or other CDC funding to a virtual standstill. Construction lenders will not fund or "roll over" to permanent financing without viable commitments from all permanent lenders. The CDC and Housing Authority are reevaluating disbursing loan funds. This has impacted some HPI projects where capital and service funding will be delayed until the economic downturn is halted. CDC is working with the State, local jurisdictions and housing advocates to promote new collaborative and risk sharing policies.

Revolving Loan Fund

- The collapse of the capital markets in 2008 negatively affected RLF operations. The Investor suspended its participation, and the search for a new investor began. Further, market conditions have made it very difficult to attract a new investor using the existing risk structure. Many potential investors are now requiring additional insulation from losses. Despite this, Los Angeles County Housing Innovation Fund, LLC (LACHIF) members have successfully identified new investors. To address the increased risk exposure to the County funds, Commission staff will now participate in the loan committee that will review each loan and have a voting right. Each loan will have to receive a unanimous vote in order to be funded. Additionally, to reduce risk, the loan to value ratio used to underwrite each loan will be reduced from 125% to 100%.

Strategy ❹ Regional Planning $3,250,000

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

Gateway Cities Council of Government (COG) • San Gabriel Valley COG • Long Beach Homeless Veterans

- San Gabriel Valley COG presented the Regional Homeless Service Strategy (Attachment B, p. 55). The final report provides valuable information about the region, and recommendations focus on three main strategic objectives to build regional capacity, resources, and will. The Strategy includes an objective to create 588 units of permanent supportive housing over the next five years.
- PATH Partners' Gateway Cities Homeless Strategy issued important recommendations (Attachment B, p. 55). Eleven recommended actions are organized in four areas: leadership, engagement, collaboration, and implementation. Actions for implementation include: homeless prevention services, a first responders program, interim housing, and permanent supportive housing. The Strategy includes plans to create 665 units of permanent supportive housing over five years.

- Long Beach Homeless Veterans outreached to over 200 veterans to make connections to services, housing, and benefits. Single Parents United N Kids (SPUNK) assisted 22 clients with a total of 28 child support cases. Of those, SPUNK closed nine client cases for a total arrears savings of $315,817.

Strategy ❺ Supportive Services Integration and Linkages to Housing $11,465,541

Clients receive integrated supportive services and housing.

Case Management • Recuperative Care • Housing Locators • Multi-disciplinary Team/Access Center • Project Homeless Connect

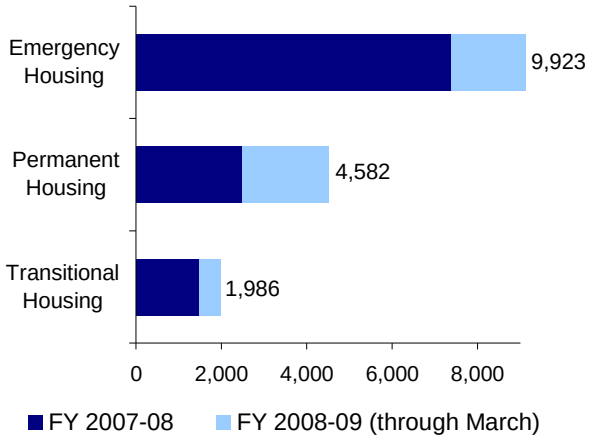
Linkages to Housing – A total of 3,866 participants received permanent housing with 59 percent being families, 17 percent transition age youth, and 24 percent individuals. In contrast, 85 percent of individuals received emergency/transitional housing placement. Chart 6 shows the number of participants who received housing; several LAHSA contracts for emergency/transitional housing ended during FY 2007-08. This quarter, 17 programs placed participants into temporary housing. Participants in these programs spent an average of 35 days in temporary housing prior to permanent or transitional housing. Participant stay in temporary housing ranged from 1-128 days.

Five programs focus on supportive services integration and linkages to housing. Two programs will serve as service integration models. In June 2009, the Weingart Center Association in partnership with JWCH Institute and the County of Los Angeles opened a state-of-the-art, 20,000 square foot Community Health Center in downtown Los Angeles. In addition, the SSI Advocacy program will increase the number of early SSI approvals by coordinating efforts between DPSS and DHS to utilize existing County medical records and improve the overall SSI application process.

Table 3: Housing Placement through March 2009	Emergency/ Transitional		Permanent Housing	
Individuals	8,012	85%	918	24%
Transition Age Youth	175	2%	666	17%
Families	1,203	13%	2,302	59%
Total	**9,390**	**100%**	**3,866**	**100%**

Services not categorized by population above: 716 who were moved into permanent housing; 1,241 who were moved into transitional housing; and 476 who were placed into emergency housing.

Chart 6: HPI Participants Receiving Housing



Supportive Services Integration – Participants received supportive services in three categories: 1) employment/education, 2) benefits advocacy and enrollment assistance, and 3) health and human services.

Employment/Education Services and Support

Through March 2009, eight HPI programs reported a total of 1,435 participants received job and/or education related supports (Table 4). Fifty-seven percent of these participants received job training, referrals, or related resources. Participants in these programs included transition age youth, chronic homeless individuals and families on Skid Row, and participants with co-occurring disorders. As programs continue to make linkages to job and education related services and build infrastructure for data collection, these numbers are expected to increase. Knowing that 90 percent of the homeless in Los Angeles are unemployed,[7] providing them with the support to overcome barriers in obtaining and maintaining employment will assist them in attaining greater self-sufficiency.

Table 4: Jobs/Education	FY 2008-09, YTD	Cumulative	Percent
Job training/referrals/resources	768	812	57%
Job placement (employment)	263	273	19%
Education (course, class, books)	329	350	24%
Total number of services provided:	**1,360**	**1,435**	**100%**

Benefits Advocacy and Enrollment Assistance

For participants who entered programs in need of specific public benefits, 11 HPI programs reported enrolling homeless individuals and families. Table 5 shows that through March 2009, 3,674 homeless individuals were enrolled into General Relief, which consisted of 70 percent of all benefit enrollments. Eight percent of participants were enrolled into Supplemental Security/Disability Income (SSI/SSDI), and 11 percent received Shelter Plus Care or Section 8 to secure permanent housing. This quarter, nearly twice as many participants enrolled into Food Stamps, which had the greatest percent increase from the previous quarter.

Table 5: Benefits	FY 2008-09, YTD	Cumulative	Percent
General Relief (and Food Stamps)	1,605	3,135	60%
General Relief only	285	539	10%
SSI/SSDI	394	442	8%
Shelter Plus Care	307	340	6%
Section 8	147	243	5%
Medi-Cal or Medicare	154	228	4%
CalWORKs	132	160	3%
Food Stamps only	117	157	3%
Veterans	23	24	1%
Total number of benefits provided:	**3,164**	**5,268**	**100%**

[7] Bring L.A. Home: The Campaign to End Homelessness; LAHSA 2005 Homeless Count.

Supportive Health and Human Services

For the current fiscal year to date, 16 programs made 15,159 linkages between participants and supportive health and human services. These programs served homeless and chronic homeless individuals, homeless families, and transition age youth. Table 6 shows 35 percent (5,333) of these HPI participants received case management, which was the most frequently reported supportive service. Followed by case management, 13 percent of linkages were for health care (1,909), and 10 percent (1,571) were for mental health care.

Knowing that 74 percent of the homeless population have a physical or mental disability, depression, alcohol or drug use, or chronic health problems,[8] linking these individuals and families with health care, mental health care, and substance abuse treatment is critical. Additionally, with the forthcoming HPRP funding, the County plans to expand services to assist families and individuals with credit repair, legal assistance, and money management. In a recent HPI survey, providers also indicated interest in improving access to child care, law enforcement, and employment support.

Eighteen programs reported providing case management services, and 10 programs selected the most intense level of case management. The HPI Report Form asked about the level of case management provided, with level one assessing the client and level three assisting with supported referrals and counseling.[9] Hours provided to each participant per month ranged from 1-80 hours (average of 17 hours) with an average caseload of 19 cases per case manager.

Table 6: Supportive Services through March 2009	FY 2008-09 YTD	Percent	FY 2007-08*
Case management	5,333	35%	2,257
Health care	1,909	13%	183
Mental health care	1,571	10%	182
Life skills	1,546	10%	676
Transportation	1,488	10%	615
Alternative court	855	6%	286
Resident rights/responsibilities	573	4%	-
Substance abuse treatment	502	3%	130
Social/community activity	475	3%	51
Food vouchers/food	324	2%	414
Recuperative care	244	1%	45
Other**	171	1%	5
Legal services	76	1%	15
Clothing/hygiene	92	1%	80
Total number of services provided to participants:	**15,159**	**100%**	**4,939**

* For FY 2007-08, this report includes LAHSA contracted programs that provided referrals to mental health care (including domestic violence counseling) and substance abuse treatment.

**Other services include: auto insurance, driver's license release, identification card, and pet care.

[8] LAHSA 2007 Greater Los Angeles Homeless Count.

[9] Post PA. Developing Outcome Measures to Evaluate Health Care for the Homeless Services. National Health Care for the Homeless Council. May 2005.

Strategy ❻ Innovative Program Design $17,569,753

Provides access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

Project 50 • Santa Monica Service Registry • Skid Row Families Demonstration Project • Homeless Courts • Housing Resource Center

INNOVATIVE PROGRAM OUTCOMES

Housing First Models

- **Housing stability**: Housing First models showed a successful 93 percent housing retention rate for individuals and families in permanent housing for six or more months. Housing First programs include: Project 50, Skid Row Families Demonstration Project, and the Santa Monica Service Registry.
- **Increased income**: After one year, Project 50 participants showed a 56 percent increase in benefits since enrollment.
- **Improvement in overall health and well-being**: At the end of one year, Project 50 participants spent significantly fewer days in ERs, hospitals, and jails with considerable cost savings for the County.

Homeless Courts

- **Pathways to self-sufficiency**: Seventy-one percent of Homeless Court participants had their warrants or citations dismissed, and they have been able to move forward by securing employment, reconnecting with their families, and planning for their future.

Los Angeles Housing Resource Center (LACHRC)

- **Information sharing**: 2.4 million searches for housing listings have been conducted online.

The HPI Report Form requested for programs to report on three outcome areas for participants receiving services for 6, 12 and 18 months. The three outcome areas were: 1) housing stability, 2) education and employment status, and 3) health and well-being. Ten programs that served chronic homeless individuals, transition age youth, and homeless individuals and families reported on these longer-term outcome areas.

Point in time outcomes for this past quarter at 6, 12, or 18 months post enrollment:

- **Housing stability**: A total of 1,279 participants continued to live in permanent housing and 1,202 continued to receive rental subsidies.
- **Employment/education**: A total of 93 participants obtained employment, 85 maintained employment, and 463 enrolled in an educational program.
- **Health and well-being**: The following number of participants continued to receive these services for six months or more: 1,485-case management; 293-health care; 351-mental health services; and 105-substance abuse treatment.

A brief description of each innovative program:

- **Project 50** – The project is a successful collaboration that includes over 24 government and non-profit agencies. Based on Common Ground's *Street to Home* strategy, Project 50 integrates housing and supportive services for vulnerable, chronic homeless individuals living near downtown Los Angeles on Skid Row. A year after its launch, the pilot successfully moved 50 vulnerable, chronic homeless individuals off of Skid Row with an impressive housing retention rate of 88 percent. Moreover, significant decreases in hospitalizations and emergency room visits indicate improved health and behavioral health outcomes. In addition to improving the quality of life for these 50 individuals, estimates show considerable cost savings as a result of fewer days spent in ERs, hospitals, and jails.

- **Skid Row Families Demonstration Project** – A total of 237 families have been placed into permanent housing. Of these families, 96 percent have successfully maintained permanent housing for six or more months (131 have maintained their permanent housing for 12 months or more, 96 families have maintained permanent housing for seven to 12 months, and 10 families are in their first six months of permanent housing). For the first six months in permanent housing, families are offered home-based case management. Consistent contact has enabled the Housing First Case Managers to develop positive relationships based on trust. Case management has included linking families to various supportive services, including: community resources, mental health referrals, school referrals, job training referrals, money management, and financial planning. After six months of home-based case management to help families stabilize, the majority of families received follow-up phone calls to ensure they are doing well and are not in crisis.

- **Homeless Courts** – A total of 877 individuals have had their warrants or citations dismissed as a result of successful completion of mental health and/or substance abuse treatment requirements of the Los Angeles County Homeless Court and Santa Monica Homeless Community Court. In addition, nine individuals have graduated from the Co-Occurring Disorders Court to have charges dismissed. As a result of having outstanding warrants, citations, or charges resolved, these individuals have been able to move forward by securing employment, reconnecting with their families, and planning for their future. For example, one participant obtained his GED, became a certified cook and hopes of owning his own restaurant. Another participant said that the program has changed his life by helping him achieve sobriety for over 17 months and reunite with his family.

- **Los Angeles County Housing Resource Center (LACHRC)** – The online database provides information on housing listings for public users, housing locators, and caseworkers. Over 2.4 million searches have been conducted by users to receive listings. The LACHRC is an excellent example of using technology to make information more accessible, and clients are very grateful for this service. Plans for adding a pre-screening feature to determine HPRP program eligibility will further improve system navigation for clients.

V. PROGRAM NARRATIVE (included in Attachment B)

Program Successes, Challenges, and Action Plans

Each quarter, programs provide information on successes, challenges, and action plans. A review has identified four common themes in implementing strategies to reduce homelessness: collaborative partnerships, innovative processes, outreach strategies, and leveraged funds.

1. Develop and strengthen *collaborative partnerships* between County departments and community-based agencies to ensure a seamless and integrated service system.
2. Support *innovative processes* that promote information sharing between service providers to better meet clients' housing and service needs.
3. Expand *outreach strategies* and education efforts to provide specialized supportive services and housing to more homeless and at-risk individuals and families.
4. *Leverage funds* to expand access to housing and services for more homeless and at-risk individuals and families.

Client Success Stories

Words of a 31 year-old single mother of a seven-year-old son who became homeless –

"It was approximately two years after I was honorably discharged from the U.S. Navy and about five months following the separation from my husband of five years. Flittering back and forth between options for a while and even went out of state for a period of time. The constant movement became tiresome, and I found the situation too toxic and demeaning to continue to expose my son.

Through these many experiences I learned it was better for me to attempt to depend on myself because that would be the only way for me to maintain my own self-respect and the respect of my son. I was very thankful when I found Hope Gardens, a temporary place to really call home.

Beyond housing, I am working on increasing my marketability so that we can do more than just survive; we would love to thrive. Education is definitely a priority for both me and my son. Since I've been at Hope Gardens, I have gone back in school to complete my A.S. in Nursing. With my degree, I can continue to grow in independence and teach my son the value of an education. Hope Gardens has been the best opportunity I have had to get my life back on track."

A story of a chronically homeless Vietnam veteran –

OPCC Project Safety Net's first permanent housing placement was with Client D, an 81-year-old veteran and 'fixture' on the Santa Monica Promenade, living in Palisades Park for the last ten years. He was homeless since returning from Vietnam in 1975; most of that time spent in San Francisco, Hollywood and Santa Monica.

Life on the streets is difficult for even the most physically fit young male— but Client D suffered worse than most. In the late 1990's, he was set on fire by youths while sleeping on the street in West Los Angeles. However, this event and others like it never stopped this active and creative individual, who has survived as a street dweller for more than a quarter of a century.

OPCC Project Safety Net began engaging with Client D in late 2008 and was able to assist him in stabilizing his life initially with a motel room and intensive staff support. With the assistance of OPCC Project Safety Net, he obtained his own Section 8 apartment with furnishings and has started working with Chrysalis Enterprises to gain part time employment—in spite of his years. Client D has a renewed sense of self-worth and self-care with surprising energy. He now acts as his own money manager, paying bills on time and consistently finding ways to improve his quality of life.

VI. RECOMMENDATIONS

County of Los Angeles Homeless Service Integration Plan
Through March 2009, the HPI offered hope to many homeless and at-risk individuals and families living in Los Angeles County. As we apply lessons learned to inform future planning efforts, we will continue to make a greater impact on the lives of many residents who need the support to achieve and sustain a safe, stable place to live.

The FY 2009-10 County of Los Angeles Homeless Service Integration Plan includes four goals:

- Support residents towards self-sufficiency to prevent homelessness;
- Increase linkages to transitional supportive services;
- Create a regional approach to housing development; and
- Enhance integration of supportive services and housing.

The Plan aligns efforts to more effectively use resources and achieve better outcomes. Focusing on a regional approach, the Plan includes expansion of successful *Housing First* models, greater access to integrated health and social services, and support for pathways to stable housing for the homeless GR population. More information about the Plan's objectives will be described in the next status report.

Homelessness Prevention and Rapid Re-Housing Program (HPRP)
With the economic recession increasing unemployment and foreclosure rates, more residents are at-risk of becoming homeless. In these difficult times, the County is experiencing a dramatic rise in requests for public assistance. Unfortunately, many of those who apply for assistance are simply not eligible due to income requirements. Therefore, the County is making a commitment to assist these residents by investing $12.1 million from the American Recovery and Reinvestment Act HPRP funding to expand housing assistance and rapid re-housing services. Moreover, the County plans to develop a seamless service system to further support individuals and families through case management and linkages to other supportive services, including household budgeting, legal services, and tenant-landlord counseling. By building on the success of HPI programs, the County will target resources towards preventing homelessness as well as strengthening network connections among providers.

Through lessons learned from the HPI, HPRP funding will focus on enhancing coordination of services. By knowing more about the broader network of available services, HPI providers could make more direct referrals and linkages for clients. In response, the HPRP proposal includes plans to add an online pre-screening feature to the LACHRC website to determine program eligibility, assist with making referrals, and improve overall system navigation.

In June 2009, the U.S. Department of Housing and Urban Development approved the County's HPRP application, and the County is to receive a grant agreement in August. Currently, County departments are working with CDC and LAHSA to be ready for implementation in October.

In summary, the CEO will continue to develop public private partnerships with cities and communities throughout the County to create regional solutions to address and reduce homelessness. To ensure the greatest return on the County's investment, the CEO holds monthly Board briefings and homeless coordination meetings that include staff from Board offices, County departments, LAHSA, CDC, and various cities to provide updates on the HPI budget and programs. The forum is an opportunity to discuss various homeless issues. Each of these efforts and the Board's continued investment will ensure that the initiative to reduce homelessness throughout Los Angeles is successful.

Pg. Strategy

Table of Homeless Prevention Initiative (HPI) Programs

	Program	Indicator (to date)	Target	Funding	Budget
	Families (I)				
3 ❶	1. Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	5,163 families received eviction prevention to prevent homelessness	2,079	One-Time	$500,000
❶	2. Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	2,935 families received moving assistance and permanent housing	1,305 450	One-Time	$1,300,000
❶	3. Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	211 families received rental subsidies to prevent homelessness	1,475	One-Time	$4,500,000
5 ❺	4. Housing Locators	573 families placed into permanent housing	n/a	*DPSS*	$1,930,000
6 ❻	5. Skid Row Families Demonstration Project	237 families placed into permanent housing	300	Board Approved	$9,212,000
	Transition Age Youth (II)				
9 ❶	6. Moving Assistance/Rental Subsidies for TAY – DCFS	388 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
9 ❶	7. Moving Assistance/Rental Subsidies for TAY – Probation	311 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
	Individuals (III)				
11 ❷	8. Access to Housing for Health (AHH)	53 clients placed into permanent housing 92% decrease in inpatient days; 81% in ER visits	115 cap	Board Approved	$3,000,000
13 ❻	9. Co-Occurring Disorders Court	43 individuals placed into transitional housing	n/a	Ongoing	$200,000
15 ❺	10. DPSS General Relief Housing Subsidy & Case Management Project	1,426 homeless GR participants received moving assistance *(to revise; evaluation report forthcoming)*	900 time	Ongoing	$4,052,000
17 ❷	11. DPSS-DHS Homeless Release Project	335 potentially homeless individuals received benefits	n/a	Ongoing	$588,000
17 ❷	12. DPSS-Sheriff's Homeless Release Project	2,327 potentially homeless individuals received benefits	n/a	Ongoing	$1,171,000
19 ❷	13. Homeless Recuperative Care Beds (DHS)	208 individuals were served through this program 67% decrease in hospitalizations; 33% in ER visits	490/2yr	One-Time	$2,489,000
20 ❺	14. Housing Specialists (most clients are individuals)	508 placed into permanent housing	n/a	*DMH MHSA*	$923,000
21 ❷	15. Just In-Reach Program	95 individuals received public benefits	Individuals 400/2 yr	One-Time	$1,500,000
24 ❹	16. Long Beach Services for Homeless Veterans (mostly individuals)	38 veterans received case management services	n/a	Ongoing	$500,000
26 ❻	17. Los Angeles County Homeless Court Program	775 individuals with citations or warrants dismissed	n/a	Ongoing	$379,000
28 ❶	18. Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program	166 single adults received moving assistance to prevent homelessness	until 2,000	One-Time	$1,100,000
29 ❻	19. Project 50	53 chronic homeless individuals placed into permanent housing	50	One-Time	$3,600,000
31 ❻	20. Santa Monica Homeless Community Court	102 individuals with citations or warrants dismissed	90	Board Approved	$540,000
33 ❻	21. Santa Monica Service Registry	43 chronic homeless individuals have participated	n/a	3rd District	$1,178,100
	Multiple Populations (IV)				
36 ❻	22. Los Angeles County Housing Resource Center	Over 2.4 million housing searches conducted	n/a	Ongoing	$202,000

Attachment B

Table of Homeless Prevention Initiative (HPI) Programs

	Program	Indicator (to date)	Target	Funding	Budget
37 ❸	23. Pre-Development Revolving Loan	Loans totaling $22 million will provide 508 housing units	n/a	One-Time	$20,000,000
38 ❺	24. Project Homeless Connect	8,848 participants were connected to services/benefits	n/a	One-Time	$45,000
39 ❸	24. **City and Community Program -CCP(V)**	$11.6 m capital, $20.6 m City Community Programs	Multiple	One-Time	$32,000,000
55 ❸	25a. **Gateway Cities Homeless Strategy -COGs (VI)**	Final report completed in March 2009	n/a	Ongoing	$135,000
55 ❹	25b. San Gabriel Valley Council of Governments	Final report completed in March 2009	n/a	Ongoing	$200,000
57 ❺	26. LAHSA contracted programs	6,614 placements into emergency housing	n/a	One-Time	$1,735,000
❺	27. Leavey Center	Program to be launched 7/09	n/a	Ongoing	*$186,000
57 ❺	28. PATH Achieve Glendale (families and individuals)	545 received case management; 43 received housing	n/a	One-time	$150,000
❺	29. SSI and Other Benefits Advocacy Program	Program to be launched 7/09	Individuals	One-Time	$2,000,000
	HPI Funding Total (excludes Board approved operational support (FY 2006-07), administrative and evaluation costs) *Ongoing costs expected to be $76,000				**$98,815,100**

39 ❸	City and Community Program (CCP) Funds	Service ($)	Capital ($)
	A Community of Friends – Permanent Supportive Housing Program	$1,800,000	
	Beyond Shelter Housing Dev. Corp. – Mason Court Apartments		$680,872
	Catalyst Foundation for AIDS Awareness and Care – Expansional Supportive Services Antelope Valley	1,800,000	
	Century Villages at Cabrillo, Inc. – Family Shelter EHAP I & II		1,900,000
	City of Pasadena – Nehemiah Court Apartments	102,685	858,587
	City of Pomona – Community Engagement & Regional Capacity Building	913,975	
	City of Pomona – Integrated Housing & Outreach Program	1,239,276	
	CLARE Foundation, Inc. – 844 Pico Blvd., Women's Recovery Center		2,050,000
	Cloudbreak Compton LLC – Compton Vets Services Center	322,493	1,381,086
	Homes for Life Foundation – HFL Vanowen	369,155	369,155
	Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley	900,000	
	Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Long Beach	1,340,047	
	Ocean Park Community Center (OPCC) – HEARTH	1,200,000	
	Skid Row Housing Trust – Skid Row Collaborative 2 (SRC2)	1,800,000	
	So. California Housing Development Corp. of L.A. – 105th and Normandie	200,000	600,000
	So. California Alcohol & Drug Programs, Inc. (SCADP) – Homeless Co-Occurring Disorders Program	1,679,472	
	Special Services for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program	1,800,000	
	The Salvation Army – Bell Shelter Step Up Program		500,000
	Union Rescue Mission – Hope Gardens Family Center	756,580 1,096,930	646,489
	Volunteers of America of Los Angeles – Strengthening Families	1,000,000	
	Women's and Children's Crisis Shelter	300,000	
	Total for Service and Capital	$18,620,613	$8,986,189
	Grand Total for CCP	**$27,606,802**	

For this report, unless specified: Year to date (YTD) refers to the first, second, and third quarters of FY 2008-09 (July 1-March 31, 2009). Cumulative refers to the number of clients served to date.

I. PROGRAMS FOR FAMILIES

1, 2, 3) DPSS Programs: Moving Assistance, Eviction Prevention, and Rental Subsidy

Goal: Assist families to move into and/or secure permanent housing.

Budget: (One-Time Funding)

1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	$500,000
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	$1,300,000
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	$4,500,000

Table A.1: DPSS Services for Families by Program
FY 2008-09, through March 31, 2009

Program (unduplicated count)	Year to Date (YTD)	Cumulative
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	2,755 received eviction prevention	5,163 received eviction prevention
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	1,449 received moving assistance and permanent housing	2,935 received moving assistance and permanent housing
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	131 received rental subsidies for permanent housing	211 received rental subsidies for permanent housing

Table A.2: DPSS Measures by Program
FY 2008-09, through March 31, 2009

Program (unduplicated count)	Number of applications received		Percent of applications approved		Average amount of grant	
	YTD	To date	YTD	To date	YTD	FY 07-08
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	4,057	7,717	68%	67%	$608	$589
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	2,021	4,312	75%	68%	$624	$629
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	137	215	96%	99%	$427	$150

Each program reported an average of three business days to approve an application.

FY 2008-09 Third Quarter	Moving Assistance	Rental Subsidy	Emergency Assistance
Homeless/At-Risk Families	346	58	854
Female	666	105	1,429
Male	432	91	1,143
Hispanic	393	85	1,659
African American	630	81	780
White	28	23	78
Asian/Pacific Islander	26	2	14
Native American	-	2	4
Other	21	3	37
15 and below	691	121	1,769
16-24	108	11	237
25-49	297	64	560
50+	2	-	4

1) Moving Assistance (MA) for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families

Successes: The Moving Assistance Program assisted 346 families to secure permanent housing.

Challenges: Although there have been many challenges with the budget, funds were identified to maintain the program thereby serving the homeless or at risk population to secure housing.

Action Plan: The action plan is to continue assisting families to secure permanent housing.

Client Success Story: A family of four was referred to a Homeless Case Manager (HCM). The family had been under the Section 8 voucher program. Apparently, the family became homeless due to their inability to keep up with the unit's rent requirement, after their voucher was reduced. The participant inquired about temporary homeless assistance (TempHA). The family was able to receive TempHA, which provided them with the opportunity to become situated in a motel. Subsequently, the participant preferred to live temporarily with her grandmother, while she searched for permanent housing. Then, the participant returned to the district office to request Permanent Homeless Assistance (PermHA). The participant found permanent housing, was approved under Section 8, and received PermHA. The participant's personal commentary on the Moving Assistance Program indicated that she was glad that all the homeless programs ran smoothly and that they were beneficial to her during her time of need.

2) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families

Successes: This program has provided rental subsidy assistance to 58 families for this quarter.

Challenges: Due to budget constraints, this program was terminated for new program applicants effective February 28, 2009.

Action Plan: The action plan is to continue assisting families that were approved prior to the termination of this program (2/28/09).

Client Success Story: A CalWORKs family who became homeless due to a domestic violence situation accessed GAIN supportive services after resolving a CalWORKs program sanction with the assistance of the participant's HCM. The participant found permanent housing from a listing the HCM provided to her from the Socialserve.com/restricted area search. The participant qualified for Permanent Homeless Assistance, Moving Assistance and the 12 Month Rental Subsidy Program. Through the collaborative efforts of the DPSS HCM, the Housing Resources Eligibility Unit, GAIN and LAHSA (shelter), this family was able to move from a DV shelter into permanent housing.

3) Emergency Assistance to Prevent Eviction (EAPE) for CalWORKs Non-Welfare-to-Work Homeless Families

Successes: The Emergency Assistance to Prevent Eviction (EAPE) Program assisted 854 families this quarter. These families were able to remain housed and/or keep their utility services.

Challenges: Although there have been numerous challenges with the budget, funding was identified to maintain this program through this fiscal year.

Action Plan: The action plan is to continue assisting as many families as possible to prevent homelessness especially through the current economic downturn.

4) Housing Locators - DPSS

Goal: Assist families to locate and secure permanent housing.
Budget: $1.93 million (DPSS CalWORKs funding)

Table A.3: Housing Locators Measures
FY 2008-09, through December 31, 2008

(unduplicated count)	YTD	Cumulative
Homeless Families	471	1,685
Housing (permanent)	210	573
Number of referrals to Program	471	1,685
Average time to place family (days)	60-180	60-180

Successes: Through the assistance of the Housing Locators, 210 families were placed into permanent housing during October-November 2008. No placements were made in December 2008.

Challenges: Due to budget constraints, the Housing Locators contract has been officially terminated effective December 15, 2008. Referrals to the Housing Locators program ended effective October 15, 2008.

Action Plan: The Housing Locator's program contract was terminated effective December 15, 2008.

5) Skid Row Families Demonstration Project

Goal: Locate 300 families outside of Skid Row and into permanent housing.
Budget: $9.212 million (Board Approved Funding)

Table A.4: Skid Row Families Demonstration Project Participants and Services
FY 2008-09, through March 31, 2009

(unduplicated clients)	Cumulative (3/31/09)		YTD	FY 2007-08
Homeless Families	300	Moving assistance	49	123
(individuals)	1,084	Eviction prevention	37	-
Female	273	Housing (emergency/transitional)	30	278
Male	27	Housing (permanent)	*237	123
		Rental subsidy	19	14
Hispanic	68			
African American	187	Education	6	2
White	12	Job training/referrals	34	25
Asian/Pacific Islander	3	Job placement	8	6
Native American	-	Section 8	12	65
Other	30			
		Case management	239	254
15 and below	619	Life skills	401	254
16-24	80	Mental health/counseling	29	17
25-49	295	Transportation	224	410
50+	15	Food vouchers	190	390

Program Specific Measures	YTD	FY 2007-08
Number of families enrolled in project	300	300
Number of families relocated from Skid Row area within 24 hours	-	-
Number of families placed into short-term emergency housing	-	300
Number of adults who received referrals to community-based resources and services	362	420
Number of children who received intervention and services	642	850
Number of families who received monitoring/follow up after 6 months case management	309	64
Number of families no longer enrolled (termination or dropped out of program)	59	50
Number of families who received an eviction notice during the last 3 months	25	-
Number of families who lost their permanent housing during the last 3 months	5	-

Emergency Housing/Case Management	Second Quarter
Average length of stay in emergency housing:	83 days
Most frequent destination (permanent housing):	2 families
Case management (level 2)	
Average number of case management hours for each participant per month:	45 hours
Total case management hours for all participants during current reporting period:	1,920 hours
Number of cases per manager:	15 cases

Longer-term Outcomes	6 mo	12 mo
Continuing to live in housing	96	131

*A total of 237 families have received permanent housing since the beginning of the program.

Additional measures to be provided after close of program:

- Gainful Employment - (Number of individuals who obtained employment)
- Access to appropriate and necessary Mental Health or substance abuse treatment - (Number of individuals who received mental health services, Number of individuals who received substance abuse treatment)
- Educational stability for children - (Number of children)
- Socialization/recreational stability for children - (Number of children)
- Services to assist domestic violence victims - (Number who received domestic violence services/counseling)

Successes: Since the beginning of the Skid Row Families Demonstration Project (SRFDP), 237 families have relocated from Skid Row to permanent housing. During this quarter, two families moved into permanent housing. Of the 237 families, 131 families have successfully maintained their permanent

housing for twelve months or more, 96 families have maintained permanent housing for seven to twelve months, and 10 families are in their first six months of permanent housing. Of the total number of families enrolled in the SRFDP, only 4 families remain pending relocation to permanent housing.

Based on the number of families remaining stable in permanent housing, it is clear that the home based case management design of the Housing First Program is successful. During the first six months of permanent housing the families receive consistent, regular home visits from their case managers. During these visits they study and discuss the "Family Survival Guide" and "Successful Household Money Management" guide to learn tools and life skills they will later be able to integrate into their every day lives. Successful plans are set in place for budgeting and paying rent and bills on time. Clients are encouraged to engage in activities in their communities, and to learn the resources available in their local neighborhood. Case managers link clients with local DMH providers, child care providers, schools, after school programs, medical clinics, transportation information and shopping locations. The family becomes invested and feels connected to the community and to their home; thus, creating further stability and potential for ongoing success. At 7 to 12 months in permanent housing, the case management follow up calls have also been instrumental. The ongoing support and foundation for the family's stability remains available to them for any of their continued needs. The case manager is available to assist with interpersonal conflict resolution, referrals to community resources, and guidance through any Housing Authority City of Los Angeles (HACLA) related procedures, such as recertification inspections, reassessment of income, or any conflict with the property owner. The majority of the families has maintained good relationships with their property owners, and has not been involved in ongoing crises related to their housing.

Challenges: The main challenge during the past quarter was working with families who could not maintain their rent after the shallow subsidy ended. As of January 2009, all clients receiving a shallow subsidy were required to pay the entire rent on their own. In order to be eligible to receive the shallow subsidy, the client was required to focus on increasing their income and financial stability with an employment plan. Throughout the time the family received the shallow subsidy, the case management focused on removing any barriers to achieving financial independence and stability. The Family Action Plans included referrals for some or all of the following: employment, adult education (GED), trade schools, mental health providers, substance abuse treatment, and domestic violence counseling. Regardless of consistent efforts from case managers to link these families with resources to achieve the goal, many were unable to remain stable. Of the 21 clients who received the shallow subsidy throughout the program, 12 have been unable to maintain or achieve increased income to pay for rent independently; 7of the 12 have suspected ongoing domestic violence issues and/or substance abuse issues that they are unwilling to admit to or address. The remaining 5 of the 12 are undocumented immigrants who have an especially difficult time increasing their income. Currently these issues, in conjunction with a very difficult job market, have made financial independence unattainable for these families.

Another systemic challenge relates to the client's change of income during the first several months of their Section 8 lease. Once the lease is signed, and the Section 8 contract begins between the client, property owner and HACLA, it takes approximately 4 to 6 months for HACLA to transfer the file and assign an advisor to the client. Only the advisor can re-evaluate the income to determine a lower share of rent/cost for the client. For example, when the client loses his job, or CalWORKs is decreased/terminated, child support payments cease, or any other decrease occurs, the client is unable to afford his rent. Previously with SRFDP funds, we were able to assist with utility bills or some portion of the rent during those episodes of transition. Currently this transition creates a crisis situation for the family.

Action plan: The shallow subsidy has been successful with nine families with higher functioning who were able to maintain gainful employment. The families who have been unsuccessful have been referred to transitional housing, substance abuse treatment programs, and domestic violence shelters where they will be able to address their ongoing crises. The priority for these families is to resolve substance abuse and/or domestic violence issues so that they are more likely to obtain gainful employment and financial stability in the future.

The crucial issue for clients residing in Section 8 housing with a change of income is the need for HACLA

to address the issue immediately. A temporary liaison between the initial HACLA advisor and the second assigned advisor could assist with income adjustments that occur during this transition, thus preventing the crisis of eviction due to non-payment of rent.

Client Success Story: Client S is a 43-year-old, African American, single mother of eight children. Five of her children are adults, and her three youngest daughters live with her, ages 17, 14, and 10.

The client and her children became homeless when they were evicted from a public housing program in 2005, after she intervened in a gang attack on her son. Family members took them in for a short time, and they then lived in a variety of shelters for the next two years. With absolutely no job skills, timed out on public social services, with the exception of receiving CalWORKs income for one child, the total family income for four was $342 per month.

While staying at the Union Rescue Mission on Skid Row, Client S was referred to Beyond Shelter by the Skid Row Assessment Team. Beyond Shelter immediately relocated the family from Skid Row to a hotel and within two months they moved to a Master Leased Apartment. Client S, full time mother of eight children, has never had a job. The Beyond Shelter case manager referred Client S to the Employment Specialist who helped her enroll in janitorial school. With some apprehension and fear, she attended the classes. She flourished and finally completed the program in November 2008, earning her first certificate of completion since sixth grade. Client S overcame her fear, her insecurity, and with constant encouragement, is now ready to seek employment. Beyond Shelter provided Client S with new clothing to attend job interviews, and she was connected with the Los Angeles Police Department to apply for a job as a janitor at a local precinct. She also has an interview at a local middle school, and has been connected with a house cleaning service provider to possibly begin working on their team as well. Her children are proud of their mother. While she was in training, Beyond Shelter paid a past due balance owed to HACLA, making her eligible once again to apply for Section 8. With her Section 8 voucher, she moved to permanent housing in a three-bedroom house near her children's schools. Beyond Shelter provided Client S with home furnishings including beds, sheets, dining table, sofa and refrigerator. She pays her rent and utilities on time, and continues working closely with her case manager to resolve conflicts and pursue her goals. All three of her children are attending school and thriving in their new home.

II. PROGRAMS FOR TRANSITION AGE YOUTH

6 and 7) Moving Assistance for Transition Age Youth

Goal: Assist Transition Age Youth (TAY) to move into and secure permanent housing.
Budget: $3.5 million (One-Time Funding)

Table B.1: Moving Assistance for Transition Age Youth Participants
FY 2008-09, through March 31, 2009

	Total	Probation		DCFS	
	YTD	YTD	Cumulative	YTD	**Cumulative
Transition Age Youth	422 (100%)	*108 (new)	311	314 (all)	388
Female	271 (64%)	48	137	223	-
Male	151 (36%)	60	174	91	-
Hispanic	112 (27%)	32	79	80	-
African American	284 (67%)	71	218	213	-
White	17 (4%)	1	9	16	-
Asian/Pacific Islander	8 (2%)	4	5	4	-
Native American/Other	-	-	-	-	-
16-24	422 (100%)	108	311	314	-

*During the First Quarter of FY 2008-09, 68 new TAY were enrolled; 35 TAY enrolled in the Second Quarter.
**FY 2007-08 DCFS demographic participant data was duplicative. 79 TAY enrolled in the Second Quarter.

Table B.2: Moving Assistance for Transition Age Youth Services
FY 2008-09, through March 31, 2009

(unduplicated count)	Total	Probation		DCFS	
	YTD	YTD	Cumulative	YTD	Cumulative
Moving assistance	238	132	253	106	161
Rental subsidy	451	142	311	309	388
Housing (permanent)	210	152	311	58	191
Eviction prevention				1	1
Any supportive service+	67	48	101	19	64
Education	57	9	-	48	58
Job training, referrals	39	-	-	31	35
Job placement	39	39	81	-	-
Case management	516	202	311	314	388
Life skills	8	-	-	8	8
Mental health	1	-	-	1	1
Transportation	77	-	-	77	94
Food vouchers	29	-	-	29	29
Clothing	58			58	58
Auto insurance	10	-	-	10	10

+Probation does not break down supportive service by type, except for job placement.

Table B.3: Longer-term Outcomes for Transition Age Youth
(6 or more months), FY 2008-09, Third Quarter

	Probation	DCFS
Continuing to live in housing	152	36
Continuing to receive rental subsidy	-	2
Obtained employment	-	9
Maintained employment	-	22
Enrolled in educational program/school	-	25
Received high school diploma/GED	-	-

DCFS data is from the Second Quarter.

Table B.4: Program Specific Measures for Transition Age Youth
FY 2008-09, Number of approvals through March 31, 2009; other measures through December 2008

	Probation		DCFS	
	YTD	Cumulative	YTD	Cumulative
Number of new approvals	108	390	184	264
Average cost per youth	$5,423	*$3,815	$1,913	*$2,663
Number of program participants satisfied with program services	129 (of 131)	216 (of 218)	66	135
Number of pregnant/parenting youth placed in permanent housing	37	90	10	71
Number exited housing	21	48	148	324
Number remaining in permanent housing and receiving assistance at 6 months	n/a	n/a	41	78

*FY 2007-08 average cost per youth.

Successes: To date, 311 youth have been placed into permanent housing.

Challenges: One of the two Probation Officers working with these clients has been out ill since November. Her clients have been difficult to supervise and more of her clients have not maintained their housing. This singles out the importance of continual follow-up with clients to help them maintain their housing.

Action Plan: Continue to monitor clients to encourage stability in housing

Client Success Story: Client M entered the DCFS system prior to her encounter with the Los Angeles County Probation Department. She was placed in her grandmother's home by DCFS, and eventually came in contact with the Juvenile Justice System. Client M was supervised by Probation for approximately four years. She has two sons, ages six and three, and she attends California State University, Northridge. Her major is Sociology, and her projected graduation date is Spring 2010. The client recently obtained employment with the County of Los Angeles as a Career Development Clerk and made permanent status. She is to complete a two-year internship in order to gain permanent status. The TPP program was able to assist Client M with her rent during her maternity stage. At that time, she was not receiving enough funds to maintain rent and her bills. As a result of the program, she resided in her first apartment for approximately 18 months, and she recently relocated to a bigger house. She was asked if she was satisfied with the program and she replied, "The TPP program is awesome. I don't know what I would have done without the assistance."

DCFS – Moving Assistance for TAY

Successes: The program continues to have great success. During this quarter 111 youth participated, 56 were new approvals. The program provided move-in assistance to 12 youth. The average spending was $64,000 per month.

Challenges: One of the two Probation Officers working with these clients has been out ill since November. Her clients have been difficult to supervise, and many of her clients have not maintained their housing. This illustrates the importance of continual follow-up with clients to help them maintain their housing.

Action Plan: The program will continue to monitor clients to encourage housing stability.

Client Success Story: A 21 year-old female resided in an apartment with one child while attending college. DCFS provided rental assistance to prevent the mother and child from becoming homeless. By assisting with rent, the youth was able to maintain stable housing as she worked towards graduation from college and to become a productive member of the community.

III. PROGRAMS FOR INDIVIDUALS

8) Access to Housing for Health (AHH)

Goal: To provide clients discharged from hospitals with case management, housing location and supportive services while permanent housing applications are processed.
Budget: $3 million (Board Approved Funding)

Table C.1 : Access to Housing for Health Participants and Services
FY 2008-09, through March 31, 2009

(unduplicated count)	YTD	Cumulative
Homeless Individuals	1	5
Chronic Homeless	29	87
Homeless Families	-	4
Female	13	39
Male	16	64
Transgender	1	1
Hispanic	4	24
African American	10	43
White	16	35
Asian/Pacific Islander	-	1
Native American	-	-
Other	-	1
15 and below	-	7
25-49	12	39
50+	18	58
Moving assistance	12	50
Housing (emergency/transitional)	30	96
Housing (permanent)	14	53
Rental subsidy	14	53

	YTD	Cumulative
Education	-	2
Job training	-	1
Job placement	-	2
General Relief	13	60
Food Stamps only	-	1
Medi-Cal/Medicare	3	32
Section 8	10	41
Public Housing Certificate	4	12
SSI/SSDI	5	28
	YTD	**Cumulative**
Case management	30	96
Health care	30	96
Life skills	30	96
Mental health/counseling	12	27
Substance abuse (outpat.)	5	16
Transportation	30	96

Program Specific Measures	YTD	Cumulative
Number of referrals	187	540
Number admitted to program (enrolled)	30	96
Pending applications	7	n/a
Number that did not meet eligibility criteria	150	444
Number of exited clients	7	27
Reduction in Emergency Department visits (12 months post enrollment, n=41)	-	81%
Reduction in number of inpatient days (12 months post enrollment, n=41)	-	92%
Number of new AHH enrollees that have a primary healthcare provider	30	96

Transitional Housing/Case Management	
Average stay at emergency/transitional housing:	128 days, 53 into permanent housing
Level 3 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	16 hours
Total case management hours for all participants during current reporting period:	780 hours
Number of cases per case manager:	10 cases

Successes: From March 1, 2007 through March 31, 2009, there were 41 AHH clients that reached their one year mark in the program. They had a combined total of 183 DHS Emergency Department visits during the 12 months prior to AHH enrollment. Post AHH enrollment, the clients only had a combined total of 34 Emergency Department visits. **The number of DHS Emergency Department visits was reduced by 81%**.

Table C.2: Longer-term Outcomes FY 2008-09, Third Quarter, Cumulative	**6 mo.**	**12 mo.**
Continuing to live in housing	22/22	22/24
Receiving rental subsidy	100%	92%
Obtained employment	-	-
Maintained employment	-	3
Enrolled in educational program	1	1
Case management	38	42
Health care	31	34
Substance abuse treatment (outpatient)	8	3
Reunited with family	5	7

The 41 AHH clients also had a combined total of 340 DHS inpatient days prior to AHH enrollment. These same clients only had 28 inpatient days post AHH enrollment. **The number of DHS inpatient days was reduced by 92%.**

Challenges: There continues to be challenges in enrolling clients that would be suitable for the program. Many of the referrals do not possess the skills for independent functioning. Many clients present with severe physical and psychiatric conditions and are unwilling to access treatment. The contract with Del Richardson and Associates, Inc. ended therefore the AHH Program has no outsourced housing locator service. The case managers on staff have absorbed this responsibility.

Action Plan: The AHH staff continues to promote the program with current referral sources and to develop new ones. A film featuring a client is played at each presentation, so that referrers can view a client's course in the program. The staff plans to continue to reconnect with referral sources on a regular basis. The AHH Project Coordinator continues to receive many referrals and these are being processed in a timely manner. In addition, the AHH Program plans to hire another case manager and an in-house housing locator to balance the present workload. The new housing locator and case manager will start in May 2009.

Client Success Stories: Mr. G is a 45 year-old Latino male who had been homeless for three months. Mr. G has been living with his mother, sister and her boyfriend; until he had to move out following a family breakdown. Mr. G was staying in a shelter downtown when he became ill and was admitted to LAC+USC for ulcers on his face and ears. This was Mr. G's third Emergency Department visit in three months, and a medical social worker referred Mr. G to the AHH program. Mr. G was diagnosed with lupus and connective tissue disease which inhibits his motor skills and affects his back, knees, buttocks and hips. In addition, Mr. G has a history of alcohol abuse and depression. He was approved for a Section 8 voucher through the County of Los Angeles and moved into an apartment in April 2008. Upon enrolling in the AHH program Mr. G has been able to address both his physical conditions through regular medical care and his alcohol abuse and depression by receiving on-going treatment from the Integrated Drug and Alcohol Treatment Program (ITP) at Homeless Health Care Los Angeles. The client has been successful in his housing for 12 months and will soon be graduating from both ITP and the AHH program. Mr. G now has the stability, independence and coping mechanisms to improve his familial relationships, manage his substance use and continue to improve his quality of life.

9) Co-Occurring Disorders Court

Goal: Assist dually diagnosed adult defendants in receiving comprehensive community-based mental health and substance abuse treatment.
Budget: $200,000 (HPI On-going Funding; pass through for DMH)

Table C.3: Co-Occurring Disorders Court Participants and Services
FY 2008-09, through March 31, 2009

(unduplicated count)	YTD	Cumulative		YTD	Cumulative
Chronic Homeless	28	63	Education	5	15
Homeless Individuals	2	2	Job training/referrals	13	22
Transition Age Youth	1	1	Job placement	-	1
			CalWORKs	-	1
Female	24	41	General Relief (GR,FS)	9	12
Male	7	25	Food Stamps only	2	3
			Medi-Cal/Medicare	6	29
			SSI/SSDI	2	27
Hispanic	3	7	Shelter Plus Care	4	2
African American	24	54			
White	3	4	Alternative court	30	39
Other	1	1	Case management	30	39
			Health care/medical	16	20
16-24		3	Life skills	27	35
25-49		38	Mental health/counseling	30	39
50+		26	Social/community activity	13	18
			Substance abuse (outpatient)	48	57
Housing (emergency)	4	8	Substance abuse (residential)	12	15
Housing (transitional)	23	43	Transportation	30	39
Rental subsidy	23	30	Clothing/hygiene	27	36

Longer-term Outcomes	6 mo.	12 mo.	18 mo.
Receiving rental subsidy	3	1	1
Enrolled in educational program, school	2	2	1
Case management	6	3	4
Health care	6	6	-
Good or improved physical health	6	1	6
Mental health/counseling	2	5	5
Good or improved mental health	5	5	5
Recuperative care	-	3	2
Substance abuse treatment (outpatient)	4	1	3
Substance abuse treatment (residential)	2	3	3
No drug use	3	-	2
Reunited with family	-	2	1

Emergency Housing/Case Management	
Average level III case management hours for each participant per month:	6 hours
Total case management hours for all participants during current reporting period:	700 hours
Number of cases per case manager:	6 cases

Successes: During the third quarter, a second cohort of CODC clients graduated, thereby increasing the total number of CODC graduates to nine. Several additional clients are expected to graduate in the next quarter. The majority of those who graduated have met their treatment, mental health, life goals, and have successfully transitioned to lower levels of care in the community. Many of the CODC clients have chosen to maintain voluntary involvement with SSG Central Mental Health even after successfully graduating. Ninety-five percent of the graduated clients continue to attend SSG's groups and partake in social activities on a weekly or more frequent basis. Others have volunteered to mentor the newly-admitted clients and to serve as inspirational role models. Ongoing client engagement and participation exemplify the powerful bonds that are created between the clients and the treatment team members over the course of the 18-month CODC treatment program. The Program continues to enhance its interagency collaboration by employing participatory communication, consensus-building, and teamwork among the various programs involved with the CODC. SSG and DMH meet regularly both at Court and at the SSG clinic. Enhanced collaboration has resulted in improvements in client care with respect to jail-to-

community transitions, medication management and psychiatric stabilization, and consistency in the rewards and consequences for clients as they progress through the program. With the new Antelope Valley Rehabilitation Center (AVRC) residential treatment component of the CODC program in its early stages of implementation, new working relationships and protocols have been established and a significant amount of cooperation and compromise from all stakeholders has facilitated the launch of this new program area. SSG has hired a part-time driver for the AVRC program, and this has resulted in additional support and supervision for the newer, at-risk CODC clients. Transportation to and from housing and appointments in the community promote compliance and continuity of care for clients, as well as decrease opportunities for temptation that may lead to relapse and/or elopement.

Table C.4: Program Specific Measures	YTD	Cumulative
Number of clients screened for enrollment	79	359
Number of clients accepted for observation	18	69
Total number of clients enrolled	22	60
Number of clients pending enrollment	-	13
Number of clients not meeting Program criteria	31	166
Number of clients rejecting/dropping out prior to enrollment	24	96
Number of clients lost during follow-up process	3	6
Number of participants in ER/crisis stabilization while enrolled in program	13	17
Average length of hospital stay (days)	5	9
Number of participants who have a primary healthcare provider while enrolled	7	38
Number of participants with new arrest(s)	14	17
Misdemeanor:	1	3
Felony:	13	10
Number of participants in jail	17	18
Average number of days in jail	32	36 (FY 07-08)

Challenges: Housing continues to be a challenge for clients. Without its own housing facility, SSG continues to rely on sober living home providers. Although SSG uses a few select providers who are generally very open to working with the CODC client population, their housing managers have been moderately receptive to the trainings offered by SSG to optimize care and supervision for clients in their residences. Additionally, the sober living placements available in Los Angeles are typically in areas where drugs are readily available, making sobriety even more challenging for the clients. There is a need for increasing supportive employment resources. While clients have demonstrated admirable success with integrating into the recovery milieu -- as evidenced by their continued affiliation with SSG even after court supervision and treatment have terminated -- this may also be indicative of a need for increased or improved community linkage establishment during the latter phases of treatment and discharge planning. Additional resources, such as an Employment Specialist or an additional Case Manager to assist with community linkages, would provide clients with more targeted assistance with developing a comprehensive community reintegration plan that may include employment, education, and/or volunteer opportunities. The development of healthy support systems outside of the CODC treatment program is of crucial importance, as clients move forward with their lives into wellness and recovery.

Action Plan: Energy is being focused on grant writing to access new funding for the areas of improvement that have been identified. The SSG program development team has been working closely with the Countywide Criminal Justice Coordination Committee (CCJCC) on a number of grant opportunities to enhance the current CODC services and expand the capacity to serve additional CODC clients.

Client Success Story (BY CLIENT): "Since I have come to the SSG, there have been many improvements in my life. Before coming to the program I was homeless and slept outside. Now I have a place to live, a sober living house. I have enjoyed living there very much and am very grateful to have such a home. I am in college at Los Angeles Trade Tech and am doing very well. Before I had struggled in school and eventually dropped out. Then all I could do was dream about being in school. Now that dream is a reality. I have been doing well in classes, making good grades. So far, they have all been A's. I am very thankful to SSG for helping me find a home and attend school. SSG has helped enrich my life and improve my situation. With their help, I have gotten on the right track."

10) DPSS General Relief (GR) Housing (Rental) Subsidy and Case Management Project

Goal: To assist the homeless GR population with a rental subsidy. In addition, coordinate access to supportive services and increase employment and benefits to reduce homelessness.

Budget: $4.052 million (HPI On-going Funding)

Table C.5: DPSS GR Housing Subsidy and Case Management Project Measures
FY 2008-09, through March 31, 2009

Moving assistance unduplicated	YTD
Chronic Homeless	322
Homeless Individuals	825
Female	444
Male	703
Hispanic	146
African American	748
White	205
Asian/Pacific Islander	30
Native American	10
Other	8
16-24	83
25-49	502
50+	146

	YTD	FY 07-08
Rental (housing) subsidy*	2,427	1,535
Moving assistance	566	860

**Unduplicated number to be provided with release of program evaluation report.*

	YTD
Education	18
Job training/referrals	440
Job placement	145
SSI/SSDI	79
Section 8	2
Veteran's	1
Case management*	2,427
Health care	360
Life skills	172
Mental health/counseling	348
Substance abuse (resident)	3
Substance abuse (outpatient)	93
Transportation	457
Recuperative care	3
Social/community event	1
Misc/other	8

Longer-term Outcomes	6 mo.	12 mo.	18 mo.
Receiving rental subsidy	516	198	104
Obtained employment	26	-	-
Maintained employment	4	1	-
Enrolled in educational program, school	2	1	-
Case management	516	26	-
Health care	-	24	-
Good or improved physical health	3	1	1
Mental health/counseling	-	198	19
Good or improved mental health	-	-	19
Recuperative care	-	4	-
Substance abuse treatment (outpatient)	-	-	104
Substance abuse treatment (residential)	19	-	-
No drug use	9	-	-
Reunited with family	-	-	-

Table C.5: DPSS GR Housing Subsidy and Case Management Project Measures
FY 2008-09, Third Quarter

	Third Quarter	YTD
Number of applications received	439	1,234
Average number of business days to approve	18	19
Average amount of rental subsidy	$292	$290
Number of individuals re-entering program	16	73
Number of SSI approvals	27	79
Percent of SSI approvals	9%	9%
Number of individuals disengaged from program	180	413

Level 1 Case Management (assessment)	
Average case management hours for each participant per month:	5 hours
Total case management hours for all participants during current reporting period:	3,861 hours
Number of cases per case manager:	68 cases

Successes: The following are successes reported for this quarter:
1. Placements - 26
2. SSI approvals - 27
3. Project districts reported 822 active subsidies for the last month of the quarter.

Challenges: It has been difficult to contact homeless participants on the waiting list.

Action Plan:
- Encourage participants to provide valid contact numbers; and
- Update the waiting list on a monthly basis.

Client Success Stories:
Ms. AR, a homeless GR employable individual volunteered for the Rapid Employment and Promotion (REP) component of the GR Opportunities for Work (GROW) Program. Ms. AR was job-ready, but due to her homeless status, she could not find a job. Ms. AR applied for GR Housing Subsidy and moved in to her new housing in January 2009. In March 2009, she found employment as a sales associate at a warehouse store.

Mr. E was accepted into the GR Housing Subsidy Program last June 2008. Mr. E had a substance abuse problem and was referred for substance abuse treatment. He applied for SSI while going through his substance abuse treatment. His initial SSI application was denied, he appealed the denial and eventually his SSI application was approved.

As a result of the General Relief Housing Subsidy and Case Management Program, the two individuals indicated above had the opportunity to have a stable residence in order to enroll/participate in programs that enabled one to seek/find employment and the other participate in a treatment program and ultimately pursue approval of his SSI application. Both individuals now have the resources to afford housing and be self-sufficient.

11 and 12) Homeless Release Projects (DPSS-DHS and DPSS-Sheriff)

Goal: Identify individuals scheduled for release who are eligible for DPSS administered benefits.
Budget: DPSS-DHS: $588,000; DPSS-Sheriff: $1.171 million (On-going Funding)

Table C.6 Homeless Release (unduplicated count) FY 2008-09, through March 31, 2009	Year to Date Total	DPSS-DHS YTD	DPSS-DHS Cumulative	DPSS-Sheriff YTD	DPSS-Sheriff Cumulative
Homeless Individuals	1,246	286	700	960	4,006
Female	410	62	*n/a	348	*n/a
Male	612	224		388	
Transgender	3	-		3	
Hispanic	389	69		320	
African American	566	128		438	
White	262	78		184	
Asian/PI	6	2		4	
Native American	4	1		3	
Other	23	8		15	
16-24	167	15		152	
25-49	640	150		490	
50+	218	121		97	
Housing (emergency)	225	61	61	75	176
Average stay (days)	9-14	14	14	12	12
CalWORKs (approvals)	35	-	1	13	38
General Relief (w/FS)	2,015	84	260	670	1,963
General Relief only	299	17	71	103	264
Food Stamps only	44	2	3	24	46
SSI/SSDI	9	-	-	12	12
Veterans' benefits	3	-	-	4	4

*Information not available for FY 2007-08.

Table C.7 Program Measures	Cumulative Total	DPSS-DHS YTD	DPSS-DHS Cumulative	DPSS-Sheriff YTD	DPSS-Sheriff Cumulative
Total referrals received	7,309	270	684	2,473	7,876
Total referrals accepted	5,041 (69%)	102	388	1,738	5,201
Of the total referrals accepted:					
Total approved	752 (YTD)	99	*99	961	2,353
Total denied	212 (YTD)	184	*184	35	121
Total pending release:	2,683 (YTD)	-	*-	1,219	-
Releases/discharges	372	94	239	133	133
Number of applications					
Food Stamps	35	-	1	12	46
General Relief	1,939	101	339	722	2,117
CalWORKs	26	-	1	13	32

Demographic information not provided for all participants

DPSS-DHS Homeless Release Project

Successes: A total of 92 homeless individuals were served by this program from January - March 2009.

Challenges: Patients are discharged on weekends making it difficult to connect homeless individuals to this program.

Action Plan: DPSS staff met with private hospital staff to discuss ways to increase the number of referrals. The Department has agreed to retrain private hospital staff on the program referral procedures and other DPSS administered programs.

DPSS-Sheriff Homeless Release Project

Successes: Participants have demonstrated gratitude for jail visits by program staff. Many have renewed optimism upon receiving emergency housing and expedited cash benefits. Quarterly meetings with Sheriff staff have improved the referral process.

Challenges: There is a limited number of hotels available in the area. Inmates are released after hours and on weekends during non-County (DPSS) work hours.

Action Plan: The action plan includes quarterly meetings with the LASD staff to discuss ways to enhance the program and connect individuals to housing and appropriate supportive services upon release.

13) Homeless Recuperative Care Beds

Goal: Homeless individuals from area hospitals receive recuperative care and are discharged to transitional or permanent housing.

Budget: $2.489 million (One-Time Funding)

Table C.8 : Homeless Recuperative Care Beds Participants and Services
FY 2008-09, through March 31, 2009

(unduplicated count)	Quarter	Cumulative
Homeless Individuals	68	208
Female	12	29
Male	56	178
Transgender	-	1
Hispanic	10	21
African American	24	41
White	18	31
Asian/Pacific Islander	2	2
Other	16	16
(race through December 2008 only)		
16-24	3	4
25-49	30	97
50+	35	107

	Cumulative
Housing (permanent)	29
Housing (transitional)	29
Housing (emergency)	36
General Relief only*	11
Medi-Cal/Medicare*	7
SSI/SSDI*	7
Case management	208
Health care	208
Life skills*	12
Mental health/counseling	1
Recuperative care	208
Transportation*	70
Substance abuse (outpatient)*	2

	Quarter	Cumulative
Number of patients referred for recuperative care beds	86	271
Number of patients admitted to recuperative care services	68	208
Number of patients who were discharged from recuperative care services	58	176
Number of patients who were assigned to a primary health care provider during recuperative care stay	68	208
Average length of stay for patients in recuperative care program (days)	21	29
Number of ER visits 6 months after being discharged from recuperative care	-	184
Number of inpatient admissions 6 months after receiving recuperative care	-	65

Emergency Housing/Case Management	
Average stay at emergency/transitional housing:	29 days
Level 3 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	4 hours
Total case management hours for all participants during current reporting period:	480 hours
Number of cases per case manager:	25 cases

* Specific service data through December 2008 only

Successes: After the first year of enrolling recuperative care participants, a six-month pre/post analysis was conducted. For these recuperative care patients, a pre/post comparison showed **a 33% reduction in ER visits and a 67% reduction in inpatient hospitalizations.**

Challenges: The most significant challenge is the lack of available and appropriate housing after discharge. In addition, a few recuperative care participants leave the facility without notice and do not return.

Action Plan: There have been increased efforts to link recuperative care services with permanent housing opportunities. A new recuperative care director was hired by JWCH to oversee all activities and to focus on addressing challenges.

Client Success Story: Client J lost his job, separated from his wife, and experiences mental health and substance abuse issues. He became homeless many years ago and has multiple health conditions, including hypertension, cellulitis and calcified hematoma. Since working with the recuperative care medical and case management staff, Client J has received a source of income and has obtained transitional housing. He is now residing near his family and church. He has been linked to a medical home and is expected to have surgery in a few months.

14) Housing Specialists - DMH

Goal: Assist homeless individuals, families, and transition age youth to obtain and maintain permanent housing. *Eighty-six percent of participants during FY 2007-08 were homeless individuals.*
Budget: $923,000 (annually in MHSA funding)

Table C.9: Housing Specialists Program Specific Measures
FY 2008-09, First Quarter and FY 2007-08

(duplicated count)	YTD	Fiscal Year
Number of referrals to program.	163	n/a
Number of property owners contacted.	330	898
Average time to place family.	n/a	n/a

Successes: Countywide Housing Specialists, funded through the Mental Health Services Act (MHSA), initiated contact with 206 unduplicated homeless participants with a mental illness during the third quarter. During the initial contact, the Housing Specialists provided a variety of housing related services such as 30 received assistance with completing and submitting a Section 8 application; 53 were referred to a Departmental funded bed in the Specialized Shelter Bed Program; 51 were assisted with moving to a transitional housing program; and 20 received financial assistance with move-in expenses.

Table C.10: Participants and Services
FY 2008-09 through March and FY 2007-08

	YTD	Fiscal Year
Chronic homeless individuals	37	-
Homeless individuals	618	2,343
Homeless families	50	255
Transition age youth	6	142
Demographic information not provided for all participants in families		
Female	415	*n/a
Male	305	
Transgender	8	
Hispanic	239	
African American	227	
White	159	
Asian/Pacific Islander	24	
Native American	3	
Other	45	
16-24	6	
25-49	660	
50+	18	
	YTD	**Cumulative**
Moving assistance	70	118
Eviction prevention	5	10
Housing (emergency)	374	1,181
Housing (transitional)	174	477
Housing (permanent)	191	508
Rental subsidy	104	208
Section 8	92	*
Mental health	458	*

*Information not available for FY 2007-08.

The Department has been notified that the allocation for the FY 2009-10 Projects for Assistance in Transition from Homelessness (PATH) grant has been increased from the current FY 2008-09. In addition, the Department is submitting a proposal in response to a Request for Proposal offered by United Way of Los Angeles through their Emergency Food and Shelter National Board Program (EFSP). The EFSP was allocated $100 million through the American Recovery and Reinvestment Act. The Department seeks to provide financial assistance to those not traditionally served through the public mental health system that are experiencing trauma stemming due to the current economic downturn.

Challenges: The Department is re-evaluating its data collection methods across all MHSA funded programs. The current reporting structure for the Countywide Housing Specialist captures the number of individual clients each housing specialist worked with during each quarter but does not reflect the labor intensiveness of this job which require multiple contacts beyond the initial contact.

Action Plan: The Department's MHSA Implementation Workgroup has established an ad hoc Data Workgroup to address the issues raised. Housing Policy & Development has altered existing forms to attempt to capture the number of unduplicated contacts each quarter along with a consistent means of reporting the status of the individuals compared to previous contacts.

15) Just In-Reach Program

Goal: Engage homeless nonviolent inmates upon entry into jail. Develop a release plan that coordinates an assessment and links clients to supportive services, benefits, and housing options upon their release. Case management team works with clients to obtain employment and explore rental subsidy eligibility.
Budget: $1,500,000 (One-Time Funding)

Table C.11 : Just In-Reach Program
FY 2008-09, through March 31, 2009

(duplicated count)	YTD		YTD
Homeless Individuals	153	Housing (emergency)	11
Chronic Homeless	209	Housing (transitional)	70
		Housing (permanent)	35
		Moving assistance	2
Female	93	Job training	192
Male	215	Job placement	19
		Education	6
Hispanic	97		
African American	137	General Relief (Food Stamps)	30
White	103	General Relief only	39
Asian/Pacific Islander	8	Food stamps only	25
Native American	3	Veterans' benefits	1
Other	38	Case management	237
(not for all participants)		Health care	2
		Mental health care	2
16-24	64	Substance abuse, outpatient	30
25-49	303	Substance abuse, residential	56
50+	40	Transportation	38
		Legal Advocacy	60

Program Specific Measures	YTD
Number of participants who received intake/enrollment	362
Number of participants who received intake/enrollment within 72 hrs of initial interview	265
Number of participants who did not complete program (exited prior to completing)	92
Number by violent crime	81
Number by non-violent crime	139
Number by area of residence prior to incarceration (most frequent residence)	
Number by area of residence prior to incarceration (second most frequent residence)	
Number of times in County jail	492
Number of times in State prison	65
Number of participants with a service plan	305
Number of participants with a service plan within a week from intake/enrollment	305
<u>Number of referrals provided to participants by type:</u>	
- Service(s): Case management, health/medical care, mental health, substance abuse treatment, transportation, and mentoring	312
- Benefit(s): CalWORKs, General Relief, Food Stamps only, Section 8 and/or Shelter Plus Care, SSI/SSDI, Medi-Cal, Veterans	95
- Job/education related service(s): Job training, employment referrals, education	40
Number of participants who do not return to jail	223

Emergency Housing/Case Management	
Average stay at emergency/transitional housing: (68 participants)	62 days
Level 2 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	4 hours
Total case management hours for all participants during current reporting period:	1,262 hours
Number of cases per case manager:	32 cases

Longer-term Outcomes (6 or more months)	YTD
Maintained permanent housing	13
Obtained employment	19
Maintained employment	4
Enrolled in educational program, school	5
Case management	144
Health care	12
Mental health/counseling	23

Successes: The Just In-Reach has established its name and reliability within the court systems resulting in participants being released to our program as an alternative to jail/prison. Staff have built a very strong relationship with certain judges and accompany clients to the court where the judge will oftentimes grant a conditional release to the JIR program and its partners.

This is a program that has been long-awaited by the Community Transition Unit (CTU) at LASD. While they have had community based organizations for years providing services to people being released from county jail, it has never been a strategic process that begins upon incarceration and walks an individual through a full continuum of care even before they are released. The one great advantage with this program is that it is leveraged by a wealth of other community resources and builds a relationship while someone is incarcerated so that when they are released they have someone to call that will provide a safety net and help them to make good choices about where they stay, getting a job, etc.

Since inception, ***over 103 clients identified as homeless or chronically homeless have been released to housing***, transitional living or a residential program. These are clients that if not for this program, would have otherwise ended up homeless on the streets. ***Out of the 362 individuals enrolled, this is a 28% placement rate which is extremely high for this population.*** Additional enrollees do not show placement for a variety of reasons – some are still in jail or state prison and continuing to work with JIR staff on a variety of issues, some have dropped out of the program or we were unable to track them once they were released so they have become inactive in our system.

Groups held in the jails have become very popular as a positive alternative to downtime. Sheriff's personnel regularly approach the JIR staff to request that they facilitate groups to the general population in the facilities. These group sessions include employment training, housing advocacy meetings, peer-to-peer mentoring, etc. The benefit to having others who are not enrolled in JIR participate is that we are able to encourage people who might not trust the system, or have one foot in the door, to seek out and take advantage of the services that are available to them. The presentation is much different coming from a civilian service organization, as opposed to the Sheriff's deputies. By building this relationship of trust, we are able to influence these individuals and they are participating in services that they would not have sought on their own upon release.

We have also been very successful in having the JIR participants call their case manager as soon as they are released so that they can make it to a safe place instead of wandering the streets or going back to a dysfunctional relationship just for the sake of housing. This ensures that they remain on the track to successful recovery instead of cycling back into the same old patterns of behavior.

Challenges: One of the challenges that we are trying to work out with the Sheriff's Department is the quick release of individuals that are in the program. Even though their jackets are flagged that they are a JIR client, when their release time comes up the Sheriff has 24-hours to release them. If that happens to be in the middle of the night and there is perceivably no one to call, they are simply let out to fend for themselves. We are still trying to get all of the LASD deputies on-board to make sure a call is made (night or day) directly to the case manager so that individual does not have a lot of downtime and are not released without a safety net.

The first three quarters of this program has seen a very high enrollment rate. In the beginning we did not qualify participants as well as we would have liked because the need is so great and the CTU staff were so happy to have a referral source for inmates in need of housing. We would like to get back to a smaller

caseload for each case manager with more focus on motivated individuals that we can spend more quality time with. The eligibility criteria for this program is made up of chronically homeless and some of the hardest to serve individuals who require more intensive focus in order to get past their barriers. Clients who have met the minimum criteria for the program have been enrolled at a high acceptance rate; however if the individual is simply motivated by the fact that they are locked up and does not seem to want to make serious life changes, then we experience a high rate of drop-outs shortly after their release.

The maintenance of our data continues to be challenging. During the past month, we have had four meetings with our database contractor, in an effort to alleviate these issues. One of the biggest challenges is that we have six organizations using this web-based system, and one individual might be working with each of those agencies for one reason or another. For example, they might show housing at a jail facility when they are "in" and then one of the housing partner providers once they are "out" and the housing advocate might be with VOA, and their temporary housing being provided by Amity. These complexities have made it difficult to design the right management system that is also web-based and has the proper security in place. The contractor has been very receptive, and we anticipate that these issues will be resolved shortly.

Action Plan: We have incentives for participants built into the program and require a strong commitment from the client before they are enrolled. Incentives include transportation upon release, clothing, money for identification cards and birth certificates, bus tokens, housing subsidy (first/last), etc. In the future clients will also be able to receive incentive credits for participating in certain activities.

We have evaluated the high enrollment rate with the LASD CTU and have created a plan to address unqualified referrals that may lack the commitment that is required to complete one year of follow-up services. We are also evaluating our staffing resources to make sure no one has a high case load that will prevent them from providing adequate attention and follow-through for their clients.

Staff will continue to complete reports manually based on data and hard copy files. Although time consuming, it is necessary at this point for accuracy.

Client Success Story: Client M is a 47-year-old male who entered the Just In-Reach Program via the Twin Towers Correctional Facility in September 2008. He was enrolled in the program as a chronically homeless individual who was displaced from his prior residence before he was incarcerated.

An intake and multiple assessments were conducted and a program plan was created for him. He was assigned a Case Manager, Employment Specialist and Housing Advocate who would work with his case intensely due to his approaching release date from jail.

JIR staff used a resource at a Lancaster area ministry that eventually offered to give the client a full time job as a maintenance worker. Staff cultivated a relationship with a local property manager that allowed Michael to defer the down payment and move in costs, under the premise of a "handshake" agreement that JIR would be monitor the transaction and his employment.

Three months after his initial enrollment in the program, Client M moved into a one-bedroom apartment. The JIR program eventually contributed $400 towards the move-in cost that was paid to the property manager. JIR staff continue to follow up with Client M as he has recently reached the 90 day employment and housing retention milestones.

16) Long Beach Services for Homeless Veterans

Goal: Assist veterans with housing, employment, SSI/SSDI, and legal issues such as child support. The program provides case management, outreach, and mental health services.
Budget: $500,000 (Ongoing Funding)

Table C.12 : Long Beach Services for Homeless Veterans
FY 2008-09, through March 31, 2009

	YTD		YTD
Homeless Individuals	222		
Chronic Homeless	17	Education	8
Homeless Families	2	Job training	3
		General Relief	6
Female	19	SSI/SSDI	6
Male	222	Veterans' benefits	14
		Case management	38
Hispanic	51	Health care	2
African American	80	Mental health	23
White	84	Substance abuse (residential)	2
Asian/Pacific Islander	9	Transportation	17
Native American	2	Other	
Other	15	Credit repaired	8
		Legal services	4
16-24	22	Drivers license reinstated	4
25-49	125		
50+	94		
Housing (emergency)	21		
Housing (transitional)	7		
Housing (permanent)	2		
Rental subsidy	12		

Program Specific Measures	YTD
Number of mental health coordination activities conducted.	-
Number of mental health assessments provided to homeless veterans by MHALA.	21
Number of meals provided to homeless veterans. (includes food/meal vouchers)	14
Number of homeless veterans whose child support payment was eliminated or reduced by SPUNK.	14
Number of outreach sessions conducted by U.S. Vets and DHHS.	14
Number of homeless veterans contacted through outreach sessions by U.S. Vets and DHHS.	212
Number of outreach sessions conducted with veterans recently returning from tour of duty.	4
Number of mental health educational pamphlets developed.	-

Successes: The partners of the Long Beach Homeless Veterans Initiative (Initiative) - the City of Long Beach (City), Mental Health America of Los Angeles (MHA), Single Parents United N Kids (SPUNK), and United States Veterans Initiative (US VETS) – continue to implement a comprehensive service package to enhance specialized services for homeless veterans. This quarter, the four partner agencies of the served 132 homeless veterans with a variety of services, including outreach, case management, child support debt reduction, psychiatric services, and housing. The veteran-specific case manager has an active caseload of ten clients, including two veterans with families. (Please note that the families are reported above with head of household information only.) At the Homeless Assistance Program Drop-In Center, MHA staff members have been triaging homeless veterans to psychiatric resources. MHA also continued to actively outreach to homeless veterans and provide them the extra supports needed to successfully connect to the VA. During the reporting period, SPUNK assisted 22 clients with a total of 28 cases. (Several clients had multiple cases.) Of those, SPUNK was able to close nine client cases for a total arrears savings of $315,817. US VETS, working in conjunction with the Long Beach Veterans Affairs system, successfully moved two clients into housing through the HUD VASH program. Both clients are attending school full-time.

The Mental Health Coordinator held a citywide mental health event on May 9, 2009 to provide educational sessions, informational booths, and health screenings to the community. This event was co-sponsored by California Assemblymember Bonnie Lowenthal and the City of Long Beach. Planning partners included

Mental Health America, Los Angeles County DMH, The Center, St. Mary's CARE Program, V.A. Hospital of Long Beach, NAMI-Long Beach Chapter, Choices Recovery Services, The Children's Clinic, and Community Hospital of Long Beach. The partners are leveraging their relationships with other agencies to provide enhanced services to the veterans. SPUNK is referring clients to the Legal Aid Foundation of Los Angeles for legal assistance with child support issues and public benefits issues. US VETS is working with the University of Southern California School of Social Work, Military Social Work and Veteran Services Program to provide Masters of Social Work interns who will work with program clients. Additionally, through a collaboration with Vets 4 Vets, seven US VETS clients attended weekend retreats for peer supported PTSD therapy. The partner agencies continue to verify veteran status and benefits with the Long Beach Veterans Affairs Healthcare System.

Challenges: The Initiative is continuing to face challenges in program staffing. Both the City's veteran-specific outreach worker and MHA's nurse practitioner left employment during the quarter. To compensate for the current vacancies, duties have been temporarily shifted to ensure continuity of service to the homeless veterans in the community. Both positions will be filled during the fourth quarter.

Action Plan· The Initiative partners will:

- Implement a citywide mental health event, proposed for May 9, 2009.
- Host ongoing coordination meetings for the Initiative, including all of the partner agencies.
- Develop partnerships with other community based organizations so to provide an expanded safety net for returning veterans.
- Utilize Homeless Management Information System (HMIS) to track and share information between Initiative partners.
- Develop and distribute informational brochures about mental health issues – A mental health brochure was approved for distribution in April 2009 and will be reported in the Quarter 4 report.
- Continue to seek additional funding for mental health and/or veterans services/housing. MHALA applied for a SAMHSA grant opportunity, Services in Supportive Housing. The purpose of this program is to help prevent or reduce chronic homelessness by funding services for individuals and families experiencing chronic homelessness in coordination with existing permanent supportive housing programs and resources.
- The City is applying for Homelessness Prevention and Rapid Re-Housing Program, authorized under the 2009 American Reinvestment and Recovery Act, which provides financial assistance, as well as housing relocation and stabilization services to individuals and families at-risk or currently experiencing homelessness. The total allocation for the City of Long Beach will be $3,566,451.

Client Success Stories: Client J is a 60-year-old permanently disabled veteran who was referred to SPUNK by his social worker at the VA Hospital in Long Beach. Client J has heart disease and recently had open-heart surgery. During one of his doctor visits, he asked the social worker for a referral for help with his child support issue as he was being billed over $18,000 in back child support. Client J's driver's license had been suspended as a result and needed assistance with getting his driver's license back so that he could drive to his medical appointments. When Client J came in he didn't have the appropriate paperwork showing that he was permanently and totally disabled, so we referred him to the VA representative that is located at U.S. VETS facility in the Villages at Cabrillo. When Client J brought in the appropriate paperwork, it was immediately faxed to the Los Angeles County Child Support Services Department. His case is now closed and his driver's license has been reinstated.

An Afghanistan veteran who is receiving SSDI recently lost his mother and custody of his daughter while in a US VETS program. Despite this overwhelming adversity, with comprehensive case management and housing provided by US VETS, he managed to refrain from using drugs or alcohol, and enroll in school as a full-time student. Through the HUD VASH program, he was finally able to get his own apartment. He continues to receive case management, remain sober, and do well in school.

Client K is 54-year-old disabled veteran suffering from extreme anxiety. Client K had been homeless for over 10 years, living out of his van. Recently, Client K was placed in a transitional housing program and was able to be reconnected with his brother and sister-in-law. Client K's family is now actively involved in the client's case management plan and plays a supportive role in his life.

17) Los Angeles County Homeless Court Program

Goal: Assist homeless individuals with clearing outstanding tickets, fines, and warrants upon successful completion of rehabilitation recovery programs for mental health, substance abuse and/or other issues.
Budget: $379,000 (On-going Funding)

Table C.13 : Los Angeles County Homeless Court Program Participants
FY 2008-09, First and Second Quarters

(duplicated count)	YTD	Cumulative		YTD	Cumulative
Homeless Individuals	758	912	Hispanic	173	209
			African American	397	475
Female	258	309	White	147	181
Male	498	600	Asian/Pacific Islander	10	10
Transgender	2	3	Native American	4	5
			Other	27	32
			15 and below	-	-
			16-24	53	69
			25-49	508	599
			50+	197	244

Program Specific Measures	YTD	Cumulative
Number of Los Angeles County Homeless Court motions received.	2,079	2,413
Number of program participants whose qualifying motions are submitted to and filed by Superior Court, and resolved within 30 days of submission.	2,079 100%	2,413 100%
Number of audited records in the Superior Court's automated case management systems (TCIS/ETRS) that are accurate.	45 100%	60
Number of motions that are granted by Superior Court.	2,037 98%	2,360
Number of motions that are denied by Superior Court.	8	8
Number of individual cases filed under the Los Angeles County Homeless Court.	2,536	2,936
Number of participants whose applications are submitted to the Los Angeles County Homeless Court within 30-days of initial contact with participant.	699	853
Number of participants that have Los Angeles County citations or warrants dismissed upon program completion.	649	775
Number of participants who complete at least 90 days of necessary case management, rehabilitative, employment or mental health services before their first appearance in Court.	747	901
Number of case managers who receive training on Los Angeles County Homeless Court benefits, application and eligibility requirements, and legal resources.	668	844

Successes: Public Counsel's greatest success this quarter was working with Los Angeles County Homeless Court Program partners to recruit a second Judge to preside over Homeless Court sessions. One challenge has been accommodating the growing number of clients at bi-monthly Homeless Court sessions. With the addition of a second Judge, they were able to hold two Homeless Court sessions on consecutive days. This will make the Homeless Court experience better for clients, by shortening their wait time to appear before the Judge and making the process more manageable for the Judge and Homeless Court staff. Holding two smaller sessions instead of one large session will also increase options on loaction, and will create less of a burden for the host agency.

During this reporting period the Superior Court achieved several milestones. First, Public Counsel members were invited to the Central Arraignment Courts to participate in an overview training of court processes. The Superior Court's goal in providing this training was to provided Public Counsel a better understanding of the detail in various data screens of the Court's automated case management systems. The information contained in those data screens becomes the basis of publicly available Court records. Secondly, the Court has created a more effective communication structure to deal with individual client issues, both internally and externally with Public Counsel.

Challenges: One challenge that inhibits our ability to make Homeless Court the most efficient and reliable program possible for our clients is the lack of consistency in the processing of Homeless Court motions and requests for resolution. One of our previous successes was in working with the Superior Court to develop a more streamlined process for handling Homeless Court motions submitted by the City Attorney and District Attorney, which has significantly reduced the processing time for those motions. However, staff continue to see significant delays in the resolution of cases in other jurisdictions. Staff have also found that some jurisdictions do not keep records of requests received and motions submitted, which means that when we follow up to check on the status of a particular case, there is no record with the responsible jurisdiction of whether the motion was ever filed. In these instances, staff has to resubmit a request for resolution, which leads to delays for the client in having his or her cases resolved. Another challenge is that some jurisdictions do not notify us once a case has been resolved. Therefore, staff periodically run the client's criminal record in order to determine whether the request for resolution was processed. Finally, staff has found with certain jurisdictions that there is a delay in updating the criminal record database to reflect the resolution of a citation, and that the resolution date is often back-dated.

A systemic challenge that has been identified is that individuals frequently are taken into custody, spend time in jail, and are then released with their outstanding citations and warrants still unresolved. This appears to have happened for about one out of every three Homeless Court clients. This means that individuals are using their once-in-a-lifetime opportunity to participate in Homeless Court to resolve citations that, in theory, should have been cleared because they spent time in custody.

Superior Court noted that in Los Angeles County there are 17 prosecutors, consisting of the District Attorney and 16 local prosecutors. The Program deals primarily with the Los Angeles City Attorney and the District Attorney. Motions from those two agencies are generally submitted by the prosecutor to the Central Arraignment Courts for judicial determination and clerical processing. A portion of motions for citations/cases prosecuted by the District Attorney and non City of Los Angeles local prosecutors continue to be handled inconsistently. This has resulted in judicial review and clerical processing delays.

Action Plan: Public Counsel has begun to address the processing issues described above by opening a dialogue with the various jurisdictions to identify where the challenges originate and how we might be able to address them. For example, the City of Long Beach does not have court clerks dedicated to processing Homeless Court motions, which often results in long delays in the motions being processed. To remedy this, the Superior Court has agreed to accept motions from Long Beach to be processed by their dedicated clerks. The program plans to work similarly with other jurisdictions to resolve any existing issues. Public Counsel discussed the issue of individuals being released from custody with outstanding citations and warrants with the Public Defender's Office and were informed that because infractions, which most of these outstanding citations and warrants are for, run on a different system and are never sent to the Court, there is very little that their office can do to address the issue. On their recommendation, staff met with representatives from the Sheriff's Department to discuss the issue and plan to meet further with representatives from the Sheriff's Department and other involved agencies in an attempt to identify a solution to this issue.

Superior Court will continue to coordinate efforts with Public Counsel to work more with the District Attorney and local prosecutors in expeditiously reviewing individual clients' cases/citations and making a determination to petition the Court for relief. This includes those prosecutors submitting their respective motions (directly or through Public Counsel) to the Central Arraignment Courts.

Client Success Story: Client A was referred to Homeless Court by his counselor at a counseling service agency where he was getting substance abuse treatment as part of his participation in the Proposition 36 program. Through Proposition 36, Mr. A had the opportunity to receive substance abuse treatment instead of being incarcerated for a drug-related offense. Homeless Court assisted Mr. A in resolving his outstanding citations, and his counselor reports that he is now working full time as a contractor in the electronics field. Mr. A is a successful graduate of Proposition 36 and has been sober for over one year. He is still fully active in his 12-step program and is living on his own.

18) Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program

Goal: Assist individuals to move into permanent housing.
Budget: $1.1 million (One-Time Funding)

Table C.14: Moving Assistance for Single Adults Program Measures
FY 2008-09, through March 31, 2009

(unduplicated count)	YTD	Cumulative		YTD
Homeless Individuals	314	492	Female	150
			Male	164
Number applications received	314	492		
Moving assistance approved	103	166	16-24	11
Percent applications approved	33%	34%	25-49	164
Average days to approve	13	*20	50+	139
Average amount of grant	$700	*$575	Hispanic	43
			African American	201
			White	55
General Relief (w/FS)	83	n/a	Asian/Pacific Islander	1
General Relief only	3	n/a	Native American	12
Food Stamps only	1	n/a	Other	2
Medi-Cal/Medicare	1	n/a		
SSI/SSDI	3	n/a	Number remaining in housing	30
Section 8	1	n/a	(after six months)	
Shelter Plus Care	10	n/a		

* FY 2007-08 average
**FY 2007-08 data not available

Successes: A steady increase in the number of referrals has been attained this quarter. Thirty participants continued to live in housing after six months.

Challenges: To date, the program is still experiencing a low number of approvals despite the increase in referrals.

Action Plan: To address the challenge indicated above, the following program enhancements are pending approval/implementation:

- Remove the time limit for previously aided participants, include CAPI participants, and process referrals from agencies providing services to the homeless population.
- Continue outreach efforts at transitional housing/shelters and other agencies providing services to the target population.

Client Success Story: Ms. AW was able to obtain and maintain a full-time job with a prestigious law firm after availing of the HPI Move-In Assistance funds to pay for security deposit to move into her permanent housing.

19) Project 50

Goal: To move 50 of the most vulnerable, chronically homeless individuals off of Skid Row and into permanent housing.
Budget: $3.6 million (Board Approved Funding)

Table C.15: Project 50 Participants and Services
FY 2008-09, through March 31, 2009

(unduplicated count)	YTD	Cumulative
Chronic Homeless Individuals (ever housed)		53
Female	-	3
Male	5	41
Transgender	-	1
Hispanic	-	11
African American	3	43
White	3	6
Asian/Pacific Islander	-	-
Native American	-	-
Other	1	1
25-49	-	4
50+	5	32
Housing (emergency)	-	41
Housing (permanent)	5	41
Rental Subsidy	-	41

	YTD	Cumulative
Education	2	2
Job training/referrals	-	2
Job placement	2	2
General Relief (GR,FS)	-	10
General Relief only	4	7
Food Stamps	-	1
Medi-Cal/Medicare	10	16
Section 8	-	1
Shelter Plus Care	5	41
SSI/SSDI	10	31
Veterans	-	8
Case management	38	41
Health care/medical	37	41
Mental health/counseling	35	38
Social/community activity	-	30
Substance abuse (outpatient)	-	20
Substance abuse (residential)	5	14
Transportation	-	35
Legal Services	-	11

Longer-term outcomes (12 months)	**Quarter**
Continuing to live in housing	41
Receiving rental subsidy	41
Obtained employment	2
Maintained employment	1
Enrolled in educational program	2
Case management	41
Health care	41
Mental health/counseling	34
Substance abuse treatment (outpatient)	30
Substance abuse treatment (residential)	5
No drug use	14
Reunited with family	3

Case Management	**Quarter**
Level 3 case management services	
Average for each participant per month:	5 hours
Total hours for all participants:	95 hours
Number of cases per case manager:	19 cases

Program Specific Measures	Quarter	Cumulative
Number of participants who exited housing	-	11
Number of participants developing individualized treatment plans	5	41
Number of participants participating in a housing retention group	-	30
Number of Project 50 participants having arrests	3	15
Number of Project 50 participants having hospitalizations	3	15
Number of Project 50 participants having an emergency room (ER) visit	2	6
Number of Project 50 participants with increased income (i.e., due to SSI/SSDI, GR)	3	16

Successes: As of March 31, 2009, Project 50 maintained 41 people in housing. Fifty-three individuals have ever been housed. This month we were able to obtain non-skid row housing for one Project 50 participant. This was a major undertaking that involved cooperation from many agencies including DMH, HACLA, SRHT and JWCH social services. We also were able to maintain housing for two participants who were about to be on the streets again. We housed five people this quarter and have two more in line for housing. We hired a new social worker, and we have successfully recruited a new Team Leader. Our CD counselors have proven to be very helpful in working with out drug addicted population.

Challenges: Keeping difficult people in housing is the major challenge of the project. Our participants continue to challenge us with their significant needs and the high degree of support they require. Working as a team, the Project 50 staff has had significant success in maintaining housing for the chronic homeless.

Action Plan:

- Utilize other agencies to assist in locating appropriate potential participants for housing. The Project 50 staff have refreshed the Registry to concentrate outreach and engagement activities on an ongoing basis;
- Encourage staff stability, maybe have a process group for participants to deal with loss;
- Continue to add participants to our list until we have 50 currently housed.

Client Success Story: Project 50 staff has housed five chronically homeless in the last quarter. Several have had over twenty five years of homelessness. One client had not slept in a bed in twenty years.

20) Santa Monica Homeless Community Court

Program funding from HPI ended June 30, 2009. Next report will provide data through program completion as well as updates on sustainability.

Goal: Assist homeless individuals with clearing outstanding citations, warrants, and misdemeanor offenses upon successful completion of mental health, substance abuse and case management.
Budget: $540,000

Table C.16: Santa Monica Homeless Community Court Participants and Services
FY 2008-09, Cumulative (February 2007 – December 2008)

(unduplicated count)	Cumulative		*Cumulative
Chronic Homeless Individuals	142	15 and below	-
		25-54**	110
Female	46	55+	32
Male	96	Housing (emer/trans)	60
		Housing (permanent)	17
Hispanic*	17	Rental subsidy	11
African American	33		
White	92	Alternative court	142
Asian/Pacific Islander	3	Case management (level 3)	135
Native American	1	Mental health	60
Other	13	Substance abuse (outpatient)	5
		Substance abuse (residential)	32

Program Specific Measures	Cumulative
Total number of clients who have enrolled in Program	142
Number of participants who appear before the Court Pilot Project that engage in case management for at least three months after their first appearance at Court	110 (77%)
Number who participate that have citations or warrants dismissed upon completion	102 (72%)
Number who receive an emergency shelter bed and remain for two weeks or longer	26 (45%)
Number who enter residential treatment complete a substance abuse program of 90 days or longer	20 (63%)
Number of arrests for all Court participants that have been placed in an emergency, therapeutic, transitional or permanent bed (or some combination of bed-types) for 90-days or longer as compared to the 90 days prior to entering residential program	80% reduction
Number of permanently housed who continue to be housed after four months, or will still be housed at the end of the program periods (which may be less then four months after housing placement)	36 (97%)
Average length of stay in emergency housing: 14-160 days	

*Latino is not categorized as a distinct race by Santa Monica Homeless Community Court
** Age range is categorized differently by Santa Monica Homeless Community Court.

Successes: The most successful ongoing collaboration which the Homeless Community Court program is engaged in is its relationship with Edelman Mental Health Center. Every Thursday morning, the Edelman psychiatrist and social worker, provide in-office services at the St. Joseph Center Homeless Services Center and occasional outreach to Homeless Community Court clients. The primary benefit of this Edelman collaboration is giving clients easy access to psychiatric care, with medications administered at two area pharmacies. Given the limited mobility, organization and/or motivation of many Court clients, this is often a superior service option to conventional mental health clinics. Integrating these psychiatric services into the pre-existing relationship which clients have with their program Case Manager and Mental Health Specialist also provides context which can help overcome service barriers stemming

directly from mental health symptoms. A secondary but lasting benefit of the Edelman collaboration is streamlining the eventual transfer of client services from in-office services at the Homeless Services Center to long-term mental health care at Edelman or other Department on Mental Health facilities.

Exodus Full Service Partnership has been another valuable collaborator with the Homeless Community Court Program. A dually diagnosed client referred to this program was rapidly entered into intensive services with an outreach case manager. Working in tandem with Homeless Community Court and Exodus staff, this client was able to access a full range of services including psychiatric care, substance abuse treatment, emergency shelter, and permanent housing at a sober living. The Full Service Partnership's collaboration with Exodus Mental Health Urgent Care Center accelerated the client's access to mental health services and dealt with acute mental health situations. This collaboration has also contributed to St. Joseph Center's familiarity with the services offered by Exodus Urgent Care, benefiting the agency more generally.

Building on the success of our Chronic Homeless Program (CHP) we have managed to link many of our CHP participants to the court which has resulted in the removal of barriers and has allowed for the successful transition by clients to the next phase of their lives.

Continued collaboration between our service providers, police and fire has allowed us to continue engaging clients in the field and seizing opportunities to refer them to the program when we think they will be receptive to services.

Our talented Public Defender is greatly appreciated not only by the Resource Coordinator but also by our service providers. She creatively strikes a balance between advocating for her clients and using her motivational interviewing techniques to help clients see the benefits of connecting to services.

Challenges: The voluntary nature of the program allows many of our most chronic, high users of police, fire and social services the opportunity to opt out of the program. These are the very people we had wished to engage in services using the authority of the court. Experience has shown us that many of our most chronic homeless do not want to access services and the voluntary nature of the program does not allow us to use the authority of the Court to connect individuals to much needed resources including mental health, psychiatric, medical, substance abuse and monetary assistance programs – all of which can be barriers to stabilizing clients, housing them and helping them maintain their housing.

Action Plan: The court will only accept participants cited with quality of life crimes – misdemeanors and infractions. The court will not accept felons or sex offenders. The very nature of the crimes, misdemeanors and infractions, prevent the court from following participant for extended periods of time and result in citations being dismissed with limited client progress. Greater oversight by the court could have a very positive influence on participants and result in better outcomes. Currently, participants average 2-3 court visits before their citations and warrants are dismissed. This impacts both our substance abuse treatment and housing placements. Indeed, because of Case Management initiated by the Court, some individuals may achieve outcomes months after their exit from the program.

Court participants would benefit from a more directive tone and more exact prescriptions from the Court. While this has improved, we continue to need progress in this area. The court appointed psychiatrist linked with the program supports this change in tone of court orders, and feels that it would result in greater client success. Furthermore, it would lend more objective finality to the process, taking out a great deal of ambiguity for the client.

21) Santa Monica Service Registry

A) Step Up on Second
Budget: $ 518,000 (Board Approved – Third District)

Table C.17: Step Up on Second, Santa Monica Service Registry
FY 2008-09, through March 31, 2009

(unduplicated clients)	YTD		YTD
Chronic Homeless Individuals	11	Moving assistance	1
		Housing (transitional), avg. 30 day stay	5
Female	4	Housing (permanent)	4
Male	7		
		General Relief with Food Stamps	1
African American	2	Medi-Cal/Medicare	1
White	8	Case management	10
Other	1	Health care	1
		Life skills	5
25-49	5	Mental health care	6
50+	6	Social/community activity	1
		Transportation	5

Case management level 3	**QTR**
Average hours per case:	6
Total number of hours:	208
Caseload per case manager:	3

Number of participants who have enrolled (entered) into program during the reporting period.	2
Number of participants who left the program during this period.	0
Total number currently enrolled in program.	11
Number of clients who received an assessment (if applicable).	2
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter.	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter.	n/a

Successes: Through the HOME Team's intensive case management efforts, five participants were successfully placed into permanent housing. Additionally, two participants were placed into transitional housing.

Challenges: The program has been unable to add individuals to the Santa Monica Service Registry, and this has kept the program from increasing its census to the maximum of 30.

Action Plan: The City of Santa Monica has begun accepting surveys on eligible individuals and will conduct assessments to add these individuals to the Service Registry. Once the City has accepted these individuals as qualifying, they will be added to the program.

Client Success Story: The program housed a female participant who had many barriers interfering with her progress. She was assisted in applying for the Santa Monica Shelter Plus Care subsidy and in locating an apartment in the community. She was able to move in and began improving her life skills, and she is working to increase her capability and maintain housing.

B) OPCC Safety Net (Access Center)
Budget: $ 660,000 (Board Approved, Third District)

Table C.18: OPCC Safety Net (Access Center)
FY 2008-09, through March 31, 2009

(unduplicated clients)	YTD		YTD
Chronic Homeless	32	Section 8	4
		SSI/SSDI	3
Female	6	Job training	3
Male	26	General Relief with Food Stamps	1
		General Relief	2
Hispanic	1	Food Stamps	2
African American	4		
White	26	Alternative court	1
Asian/Pacific Islander	0	Case management	30
Native American	0	Health care	10
Other	1	Mental health care	11
		Substance abuse treatment (residential)	3
25-49	13	Substance abuse treatment (outpatient)	5
50+	19	Food	7
		Clothing	7
Housing (emergency)	24	Transportation	9
Housing (transitional)	7		
Housing (permanent)	3	Case management level 3	
Rental subsidy	1	Average hours per case:	34
		Total number of hours:	1,028
Average stay in temporary housing is 44 days		Caseload per case manager:	10

Number of organizations/agencies that your program has a formal collaboration for this project.	3
Number of times collaborative partners met each month.	2
Total amount ($) of HPI funding leveraged for project.	n/a
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).	n/a
Number of participants who have enrolled (entered) into program during the reporting period.	5
Number of participants who left the program during this period.	0
Total number currently enrolled in program.	32
Number of clients who received an assessment (if applicable).	7
Cost per participant.	$2,711
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter.	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter.	n/a

Successes: OPCC Project Safety Net has completed hiring of the staff team with the addition of a consulting psychiatrist and a social worker/clinical consultant who comes to OPCC with a joint background in social work and public health (MSW/MPH).

Among the 40 most vulnerable chronically homeless clients identified since December, OPCC Project Safety Net has engaged a total of 32 individuals with intensive outreach and case management; eight individuals are reportedly missing or left the area. OPCC is working with the City of Santa Monica to identify and confirm eight high priority individuals to be added to the Service Registry in place of those who left the City. Thirty individuals have completed Intake Assessments. A total of 29 clients are off the street residing in temporary, emergency or transitional housing including 3 individuals in permanent housing (1 – skilled nursing facility, 1 – board and care, 1 – Section 8 apartment). Three individuals are scheduled to move into permanent housing in April and May. Two additional Section 8 voucher holders are conducting apartment searches and nine clients are awaiting voucher issuance from Santa Monica Housing Authority. Outcomes during this quarter include benefits establishment for 6 individuals (3 approved for General Relief and 3 approved for SSI/SSDI). Master lease agreements are in place and OPCC is negotiating a public/private partnership with a private developer and the City of Santa Monica for renovation and long term lease of a 50 unit assisted-living facility with plans for SRO conversion.

Challenges: Housing: The shortage of low-income housing in Santa Monica community is a challenge we are working to overcome in developing relationships with apartment owners and property management companies. The majority of clients have multiple obstacles such as poor credit histories and other special needs related to years of living on the streets with untreated mental illness and/or substance addiction. The use of motel vouchers has been critical in stabilizing clients and developing essential life skills needed to secure and maintain permanent housing. The length of time to secure a Section 8 voucher (averaging two months) has delayed the housing placement process. OPCC Safety Net is awaiting approval from the City of Santa Monica Housing Authority for a master lease arrangement between OPCC and local landlords, with a transfer of lease to eligible program participants.

Substance Abuse and Mental Illness issues: Many clients struggle with severe substance addiction and untreated mental illness. While in most cases staff have been able to work with each client to establish a higher quality of life, resistance to treatment and relapse is an ongoing factor impacting housing placement.

Action Plan: The addition of a psychiatrist and social worker with expertise in public health will increase staff capability to effectively engage individuals with untreated mental illness, substance addiction and other health issues. OPCC will move forward in planning and negotiations to secure a 50 unit assisted-living facility planned for SRO housing conversion. OPCC will continue to work with the Santa Monica Housing Authority to pursue master lease arrangements linked to the Section 8 program and advocate for a shorter timeframe for the Section 8 application approval process. Our housing coordinator will collaborate with other OPCC housing coordinators to develop innovative recruitment strategies with landlords to secure available housing stock.

OPCC received a donation of an electric golf cart and priority will be given to the OPCC Project Safety Net Team to transport clients to services.

Client Success Story: OPCC Project Safety Net's first permanent housing placement was with Client D, an 81 year old veteran and 'fixture' on the Santa Monica Promenade, living in Palisades Park for the last ten years. He was homeless since returning from Vietnam in 1975; most of that time spent in San Francisco, Hollywood and Santa Monica.

Life on the streets is difficult for even the most physically fit young male— but Client D suffered worse than most. In the late 1990's, he was set on fire by youths while sleeping on the street in West Los Angeles. However, this event and others like it never stopped this active and creative individual, who has survived as a street dweller for more than a quarter of a century.

OPCC Project Safety Net began engaging with Client D in late 2008 and was able to assist him in stabilizing his life initially with a motel room and intensive staff support. With the assistance of OPCC Project Safety Net, he obtained his own Section 8 apartment with furnishings and has started working with Chrysalis Enterprises to gain part time employment—in spite of his years. Client D has a renewed sense of self-worth and self-care with surprising energy. He now acts as his own money manager, paying bills on time and consistently finding ways to improve his quality of life.

IV. PROGRAMS FOR MULTIPLE POPULATIONS

22) Los Angeles County Housing Resource Center, (formerly known as the Housing Database)

Goal: Provide information on housing listings to public users, housing locators, and caseworkers.
Budget: $382,000 ($202,000 allocation from HPI funding and $180,000 from CDC).

Table D1: LACHRC Program Measures June 1, 2007 – March 31, 2009	Cumulative	Year 1 6.1.07 - 6.30.08
Number of landlords registered on the site	4,629 *630 new*	3,505
Average monthly number of units available for rental	2,142	1,814
Total housing unit/ apartment complex listings registered on site (includes units that have been leased) *(as of December 2008)*	6,075 *904 new*	5,171
Total number of housing searches conducted by users that returned listing results	2,485,663 *399,509 new*	1,590,825
Average number of calls made/received to the Socialserve.com toll-free call center per month	3,093	2,897
Number of collaborative efforts forged between County Departments, Cities, and other stakeholder agencies: *Public Counsel, JWCH Institute, ISD – Urban Research Unit, Pasadena, Economic Redevelopment Division, County Public Information Office, City of Los Angeles Dept of Aging, Westside Center for Independent Living, Pasadena Union Station Foundation, Hathaway-Sycamores Child & Family Services, Fannie Mae*	38	33

Successes: The contract administration was successfully moved from the County to the Community Development Commission in March. The Board approval of additional funding from the CEO-IT Fund will allow the project to expand to Phase II beginning immediately. The Housing Resource Center also launched a new for-sale Housing component and foreclosure resource page in April. Fannie Mae has partnered with the CDC for the NSP/HERO program and is exporting lists of their foreclosed properties for display on the Housing Resource Center website.

Challenges: The contractor (Socialserve.com) statistics continue to show that the ration of LAC-HRC web page searches to available units is over 80% higher than other metropolitan areas. This demonstrates the need (and challenge) of outreaching to more L.A. County landlords to get more rental listings on the web page to serve this extraordinary demand.

Action Plan: The CDC is proposing to use the LA County Housing Resource Center as an on-line pre-screening tool to assist County departments with implementation of the Homelessness Prevention and Rapid Re-housing programs being funded under the American Recovery and Reinvestment Act (ARRA).

Client Success Story:
The following tenant quote came in February: "I am elderly and disabled and lost my home due to foreclosure. I have called agencies throughout Los Angeles County looking for housing. I can't find anything I can afford. I was at my wits end last night and called 211. They gave me your number. I am so please to have been helped so promptly. You gave me pricing and direct contact numbers. You gave me more help than any agency located in my city."

23) Pre-Development Revolving Loan Fund (RLF)
Goal: Affordable housing developers will receive loans directly from the Los Angeles County Housing Innovation Fund, LLC (LACHIF) to build much needed affordable housing in Los Angeles County.
Budget: $20 million

Table D.2: Pre-development Revolving Loan Fund	Quarter/FY
Number of applications received that are eligible for the RLF.	7
Number of projects with a complete environmental review within 90 days.	-
Number of projects with environmental clearance.	-
Average amount of time from receipt of application to loan approval.	-
Dollar ($) amount of loans distributed by LLC.	-
Average length of time from loan close to loan maturity date.	-
Average length of time from anticipated construction start to end date.	-
Number of loans approved.	-
Number categorized as predevelopment.	-
Number categorized as land acquisition.	6
Number of loans by Supervisorial District.	
Supervisorial District 1	2
Supervisorial District 2	2
Supervisorial District 3	-
Supervisorial District 4	-
Supervisorial District 5	2
Number of special needs households to be served by each loan.	187
Number of low-income households to be served by each loan.	321
Number of proposed total and affordable housing units.	321
Number of housing units to be developed at 60% or below AMI.	508
Number of housing units to be developed at 35% or below AMI.	-
Number of reports collected on time from LLC.	2
Number/percent of lost loans (live to date).	-

On June 10, 2008 the Board of Supervisors approved and authorized the Commission's Executive Director to execute an Agreement with LACHIF for administration of a Revolving Loan Fund for developers of affordable housing to assist them with predevelopment and acquisition activities. The Agreement was executed by all parties on June 20, 2008. The Loan Agreement legally binds the Commission to fund the LACHIF with $10,030,000 by June 30, 2008 and $9,800,000 by June 30, 2009. The first installment of $10,030,000 was wired by the Commission to LACHIF on June 27, 2008.

The original structure outlined in the Agreement included a Senior Participant Investor (Investor). The United Methodist Church Pension Fund was selected and agreed to provide $32,100,000 to the fund. LACHIF members committed to providing $8,100,000 to the fund. The collapse of the capital markets in 2008 negatively affected RLF operations. The Investor suspended its participation, and the RLF was suspended until a new investor could be obtained. Further, market conditions have made it very difficult to attract a new investor using the existing risk structure.

Many potential investors are now requiring additional insulation from losses because of the huge losses they have suffered. Despite this, LACHIF members have successfully identified new investors. However, to optimize the pool of possible investors the risk structure of the RLF will need to be changed. Whereas the original risk structure called for the County to take only a 33% loss on each loan, the new risk structure calls for the County to take a 33% loss on each loan and cover the investor funds up to the total County investment amount of $19.8 million. To address the increased risk exposure to the County funds, Commission staff will now participate in the loan committee that will review each loan and have a voting right. Each loan will have to receive a unanimous vote in order to be funded. Additionally, to reduce risk the loan to value ratio used to underwrite each loan will be reduced from 125% to 100%.

24) Project Homeless Connect

Goal: Provide individuals and families with connections to health and human services and public benefits to prevent and reduce homelessness.

Budget: $45,000

Project Homeless Connect (PHC) is designed to bring government, community-based, and faith-based service providers together, as well as other sectors of the local community, to provide hospitality, information, and connections to health and human services and public benefits to homeless individuals and families. PHC provides a unique opportunity for homeless individuals and families to access services in a supportive, community-based, "one-stop shop" setting. The Los Angeles County, Chief Executive Office participates as the lead organizer for local PHC Day events, which normally take place during the first week of December; however, recent need and popularity of PHC Day events have created a situation where the CEO's Office is being requested to plan events on an ongoing, year-round basis.

Successes: Between December 2006, which is the first year the County CEO served as the event coordinator, and February 2009, PHC Day events have served to connect/engage 8,848 homeless participants to public benefits, health and mental health screenings, dental services, voice mail service, substance and alcohol treatment and diversion services, food distribution programs, alternative courts and legal assistance, immunizations, vaccines and flu shots, domestic violence services and shelter, parenting classes, various types of housing, and other health and human services. On April 16, 2009, 115 clients attended the first annual Whittier Connect Day event; approximately 20% of the guests at the Whittier event were classified as "at-risk" of homelessness.

Challenges: Due to the current economy and the fact that families and individuals are losing their homes due to property foreclosures, future Connect events will need to continue to target the at-risk population.

Table D.3: Project Homeless Connect

Fiscal Year	Emergency Housing	Transitional Housing	Permanent Housing
FY 2006-07	59	-	70
FY 2007-08	117	19	-
FY 2008-09	234	78	25
Total	410	97	95

V. CITY AND COMMUNITY PROGRAM (CCP)

Capital Projects

Successes: The CDC is in constant contact with all of the Capital Developers regarding the projects. The CDC has set up internal tracking systems to monitor project progress. The timeline for execution is being determined based on the need of each grantee. It is customary for grants to be executed near the start of construction. Bell Shelter has executed the loan agreement and purchased the property for the project. All funds granted to the project have been expended.

Challenges: Challenges continue from the previous quarter. Coordination with other local, state and/or federal funding and construction industry changes has caused delays. Projects that were expecting state MHP funding are on hold because of the "freeze" caused by the State budget. The state has started to release some funding, but it is unknown at this time which HHPF projects will be affected.

Action Plan: Continuing from the previous quarter, the CDC is determining with each developer, whether or not to enter into the grant agreements soon or if it is best to wait until near the beginning of construction to avoid the necessity of several amendments. The CDC staff is providing technical assistance and will be conducting site visits to projects that are seeking funding for rehab of existing buildings.

Cumulative Expenditures to Date: $922,227

Service Projects

Successes: To date, the CDC has executed all but one of the 15 service contracts that are ready to be implemented. The two contract amounts for City of Pomona were inadvertently reversed in the Board Letter dated April 22, 2008 and subsequent award letters dated May 2, 2008. We have executed the contract that reflected the lower amount authorized by the Board action. For the contract that is short of the needed amount for the project, we are in the process of filing a motion or a Board letter to approve an amendment to bring in the additional funds for the full amount needed by the project. We have worked extensively with our Risk Manager to facilitate the review and approval of insurance documentation for both the HHPF/CCP agencies and their subcontractors, while still meeting the County's mandated requirements. Our Risk Manager and County Counsel have revised the language in our contracts so that the responsibility to verify subcontractor compliance with insurance requirements will be with our contracted agencies instead of the CDC. We have also strengthened the indemnification provisions in our contracts. This change will streamline the approval of subcontracts in the future. Most agencies have begun the implementation of their programs and have recruited program staff and developed subcontract agreements with the identified collaborators. Most have also begun expending funds and have requested reimbursement of costs or plan to do so in the next month. To that end, the CDC has assisted a number of agencies in the submittal of payment requests and required documentation to support expenditures.

Challenges: A number of agencies had not used automated systems extensively and were challenged by the CDC's automated systems for digital contract execution and submittal of payment requests. We have provided extensive technical assistance in these areas and have successfully resolved all concerns. One service provider, United States Veterans Initiative, notified us that they would not be able to provide services to the Compton Vets Service Center after it is completed. The developer, Cloudbreak Compton, LLC has provided some preliminary alternative options in their search for another service provider. We anticipate their submittal of revised plans in the next quarter 2009 and will evaluate the proposal accordingly.

Action Plan: Our next challenge will be the implementation of the programmatic and financial monitoring of these projects. We have recruited for one additional staff to assist in this process. We are planning a second annual comprehensive training for all service agencies to address all areas of technical assistance concerning contract compliance.

Cumulative Expenditures to Date: $539,121

25. City and Community Program (CCP)

a. A Community of Friends (ACOF) – Permanent Supportive Housing Program
b. Ocean Park Community Center (OPCC) HEARTH
c. Catalyst Foundation for AIDS Awareness and Care –Supportive Services Antelope Valley
d. Homes for Life Foundation – Vanowen Apartments
e. Hope Gardens Family Center (Union Rescue Mission)
f. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in the Antelope Valley
g. Skid Row Housing Trust – Skid Row Collaborative (SRC2)
h. Southern California Alcohol and Drug Programs – Homeless Co-Occurring Disorders Program
i. Volunteers of America Los Angeles – Strengthening Families
j. Women's and Children's Crisis Shelter

25a) A Community of Friends (ACOF) - Permanent Supportive Housing Program
Budget: $1,800,000 (City and Community Program)

Table D.1: ACOF
FY 2008-09, July 1, 2008 – March 31, 2009

(unduplicated count)	YTD		YTD
Homeless Individuals	175	Education	26
Chronic Homeless	36	Job training, referrals	19
Homeless Families	114	Job placement	21
Female	305	CalWORKs	75
Male	258	General Relief w/Food Stamps	41
Transgender	1	General Relief only	3
		Food Stamps	3
Hispanic	141	Medi-Cal/Medicare	5
African American	314	Shelter Plus Care	26
White	98	SSI/SSDI	226
Asian/Pacific Islander	7		
Native American	-	Alternative court	3
Other	4	Case management	325
		Life skills	325
15 and below	171	Mental health	286
16-24	65	Health care	160
25-49	213	Social/community activity	267
50+	115	Substance abuse treatment (outpatient)	79
		Substance abuse (residential)	5
Moving assistance	11	Transportation	166
Eviction prevention	16	Residential management support	324
Rental subsidy	325		
Housing (permanent)	325	Case management (level II)	
		Average hours per case:	10 hours
		Total number of hours:	6,425 hours
		Caseload:	16 cases
Longer-term Outcomes (six or more months)			
Maintaining permanent housing			319
Receiving rental subsidy			319
Obtained employment			23
Maintained employment			41
Enrolled in educational program, school			30
Case management			295
Health care			253
Good or improved physical health			40

Successes: During this reporting period, A Community of Friends is pleased to report that the HPI funding has led to a successful collaboration with the Housing Works Mobile Integrated Service Team (MIST team). Collaboration with the MIST Team continues to provide for case management services, allow for additional supportive services through Resident Management support systems, and provide for needed property maintenance. The MIST team and case management staff have met regularly to ensure a continued overlay of needed services for “at risk” tenants, played an integral role in preventing evictions for those residents in jeopardy of losing housing, and case management staff has been able to ensure that the majority of residents remain permanently housed in a safe and healthy environment.

Challenges: The greatest challenge continues to be the reporting tool itself. While it may be effective to use one tool to collect data across programs, this sometimes makes it difficult to capture date not specifically stated in the reporting tool. For example, spouses and adults often enter or leave mid quarter, affecting the demographic counts for gender, race, and age. Also, adults in families are often not counted as having received a service, as they are not the "head of household." Yet spouses and adult members of the household are often indirect beneficiaries of the services provided. Additionally, combining data from different collaborators and properties presents a tracking challenge. Challenges the tenants face include on-going struggles with substance abuse, correctly budgeting funds each month, managing medication, and improving life skills to a level which increases self sufficiency.

Action Plan: ACOF has worked with County staff to clarify the reporting process and make minor adjustments that will ensure the correct capture of data. Now that a baseline has been established, only data for those entering will be collected and HPI staff will merge that data. This will ensure that there are not duplicate counts or counts including newly added adults in families.

Case Management staff will continue to work with the MIST team to focus on those individuals most at risk of losing their housing. In addition, case management staff will work with Resident Managers on "best practices" to increase support when case management staff are unavailable on nights and weekends.

Client Success Story: Tenant V suffers from a chronic mental health disorder and cancer, and she was homeless for a total of nine months before finding permanent housing through A Community of Friends (ACOF) at Woodland Terrace Apartments. Tenant V struggled through the system to maintain custody of one child and regain custody of another while she resided at shelters and received services enabling her to obtain vouchers for motels while undergoing the application process for permanent housing. Tenant V availed herself of onsite case management services immediately upon moving into Woodland Terrace. The onsite case manager was able to assist Tenant V in maintaining stability and treatment of her mental health disorder, becoming familiar with the community, accessing community services, utilizing public transportation, obtaining and maintaining residential stability, and maintaining a stable environment for her children. Case management staff also assisted Tenant V in seeking treatment for her cancer and in obtaining much needed emotional support through both on site and off-site services.

As Tenant V became more stabilized, she began to display a great desire to assist other tenants who were struggling or were new to the building. Tenant V began to help parents watch their children and encouraged tenants to help each other with on-going childcare needs in addition to accessing community childcare. As Tenant V was able to learn money management skills she began to also help other tenants by demonstrating to them what she had learned. As transportation became an issue for some tenants, Tenant V was able to assist by showing them the neighborhood and in some cases giving them rides to enhance the community experience. During this past quarter, Tenant V was doing so well that she was asked to serve as Tenant President of On-Site Activities. In this role, Tenant V takes the input she has received from other tenants and meets with the on-site case management staff each week to provide much valued tenant input regarding on-site groups, children’s activities, and community meeting needs. Tenant V also assists case management staff in putting together the Community Calendar each month so that activities meet current tenant needs. Tenant V is a wonderful success not just because she overcame many obstacles but because of her constant helpful and positive attitude to the tenants at Woodland Terrace Apartments.

	YTD
Number of organizations that your program has a formal collaboration for this project.	1
Number of times collaborative partners met each month.	25
Total amount ($) of HPI funding leveraged for project.	$1,775,550
Percent of HPI funding leveraged for project.	33%

	YTD
Number of participants who have enrolled into program during the reporting period.	8
Number of participants who left the program during this period.	5
Total number currently enrolled in program.	320
Number of clients who received an assessment (if applicable).	n/a
Cost per participant.	$2,645
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter.	11
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter.	8
Program Specific Question:	
Number of participants who received benefits (as a result of the program).	379

25b) Ocean Park Community Center (OPCC) HEARTH
Budget: $1,200,000 (City and Community Program)

Table D.2: OPCC HEARTH
FY 2008-09, through March 31, 2009

(unduplicated count)	YTD		YTD
Homeless Individuals	179	Education	-
Chronic Homeless	148	Job training, referrals	2
Transition Age Youth	16	Job placement	-
Female	105	General Relief w/Food Stamps	-
Male	238	Food Stamps	1
		Shelter Plus Care	4
		Section 8	6
Hispanic	50	SSI/SSDI	1
African American	98	Medi-Cal/Medicare	1
White	163		
Asian/Pacific Islander	9	Case management	68
Native American	2	Life skills	10
Other	21	Mental health	6
		Health care	343
		Social/community activity	32
15 and below	8	Recuperative care	33
16-24	16	Substance abuse (outpatient)	7
25-49	187	Transportation	38
50+	132	California identification	4
		Veterans	1
Moving assistance	5	Legal	1
Housing (emergency)	8	Locker	4
Housing (permanent)	10	Case management (level III)	
Housing (transitional)	5	Average hours per case:	52
		Total number of hours:	1,088
		Caseload:	22

	YTD
Number of organizations that your program has a formal collaboration for this project.	4
Number of times collaborative partners met each month.	4
Total amount ($) of HPI funding leveraged for project.	$386,770
Percent of HPI funding leveraged for project.	84%
Number of participants who have enrolled into program during the reporting period.	154
Number of participants who left the program during this period.	-
Total number currently enrolled in program.	343
Number of clients who received an assessment (if applicable).	37
Cost per participant.	$116
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter.	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter.	n/a
Program Specific Question:	
Number of participants who received benefits (as a result of the program).	9

Clients spent an average of 23 days in temporary housing; 2 participants were placed into permanent housing; 1 participant has stayed in permanent housing for six months.

Successes: OPCC Project HEARTH convened regular meetings with all project collaborators including: Venice Family Clinic (VFC) Medical Director, Operations Director, Physician, Grants' Manager, OPCC Samoshel and Access Center directors, managers and project staff. Meetings were held to ensure a seamless service delivery and to refine intake and referral procedures and protocols. In January, the respite beds were made available to St John's Hospital, and 26 beds were occupied by both referrals from the Venice Family clinic and St. John's Hospital. Project HEARTH conducted orientation with discharge planning staff from Santa Monica/UCLA Medical Center.

Additionally, a Project HEARTH Housing group was developed to provide information to participants about the different housing options available. Clients enrolled in Project HEARTH have the option of attending a weekly HEARTH Housing Meeting, which focuses on permanent housing options, such as subsidized housing, senior low-income housing, Section 8, skilled nursing facilities, and shared community living. Clients were also presented with information that will benefit their housing goals, such as: cleaning up their credit, opening a bank account, presenting well to landlords, and how to be a good tenant. From participating in the housing groups, clients have often commented that they are happy to hear all the latest housing information, which makes them feel hopeful and grateful.

During the third quarter, OPCC Project HEARTH provided primary care medical services through VFC Physician and Clinic coordinator which served 154 individuals on-site at OPCC's Access Center. Additionally, 37 intake assessments were completed, 26 respite beds were occupied, nine clients were placed in emergency/transitional housing and six clients were permanently housed.

Challenges: Combining data from different collaborators into one report continues to be a challenge. OPCC developed a computerized data tracking system for this grant. We expect that the problems will be resolved by next quarter.

Challenges faced by our clients include a multitude of struggles with substance addiction, severe untreated and chronic mental health issues and very poor physical health conditions which impede their ability to become self sufficient. The absence of adequate low income housing in the Santa Monica community is also a major challenge as it is difficult to locate landlords who are willing to give our clients – who often have poor credit histories, due to living on the streets, and have many other special needs – a chance. Additionally, the process of assisting clients in obtaining a Section 8 voucher is a long and time consuming process.

Action Plan: OPCC will work closely with our IT consultant to ensure that the problems on the data tracking system will be completed by next quarter.

Additionally, our case management staff and housing coordinator will continue to work on creative and innovative ways to find community housing alternatives for our clients who have a limited income. Our case managers will also promote other types of permanent housing such as board and care, independent living, and additional resources in the Santa Monica area. They will also continue to work on new landlord recruitment.

Client Success Story: Mr. F came to OPCC Access Center in March 2009. Wheelchair bound due to having a left leg amputated, he was also in pain due to recent eye surgery. He had been homeless since 2008 and had recently taken residence in a garage of an abandoned home.

Venice Family Clinic provided medical care co-located on site at the Access Center; however, with no respite housing available following care, his eye was at risk of infection. Mr. F requested a convalescent home; however, his Medi-Cal was inactive, leaving him with no medical insurance. Project HEARTH staff spent the next three days making phone calls to Medi-Cal. Meanwhile, the ACCESS Center staff provided a motel voucher to Mr. F for interim respite care.

Five days after first meeting Mr. F, Project HEARTH staff was able to re-instate his Medi-Cal benefits and moved Mr. F into Royal Oaks Care Center. The client reported that he is happy at his placement and said, "I found my angels who helped me in my time of need. Thank you."

25c) Catalyst Foundation for AIDS Awareness and Care - Supportive Services Antelope Valley
Budget: $1,800,000 (City and Community Program)

Table D.3: Catalyst Foundation
FY 2008-09, through March 31, 2009

(unduplicated clients)	YTD		YTD
At-risk Individuals	816	Moving assistance	3
At-risk Families	50	Eviction prevention	2
		Rental subsidy	1
Female	492		
Male	561	Education	383
Transgender	2	General Relief	51
		Medi-Cal/Medicare	3
Hispanic	302	Section 8	2
African American	349	Case management	28
White	334	Health care	622
Asian/Pacific Islander	13	Life skills	383
Native American	9	Mental health care	55
Other	30	Transportation	65
		Food	88
15 and under	1	Pet food/vet care	99
16-24	436		
25-49	241		
50+	112		

Longer-term outcomes (6 months)	
Continuing to live in housing	390
Receiving rental subsidy	1
Case management	20
Health care	192
Level 3 case management services	Quarter
Average for each participant per month:	5 hours
Total hours for all participants:	420 hours
Number of cases per case manager:	28 cases
Number of organizations/agencies that your program has a formal collaboration for this project.	33
Number of times collaborative partners met each month.	1
Total amount ($) of HPI funding leveraged for project.	$696,919
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).	46%
Number of participants who have enrolled (entered) into program during the reporting period.	333
Number of participants who left the program during this period.	-
Total number currently enrolled in program.	1,141
Number of clients who received an assessment (if applicable).	28
Cost per participant.	$863
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.	n/a

Successes: The Catalyst Foundation was able to provide services to disenfranchised communities that are at high risk for homelessness. Services provided allow our clients to continue to maintain independent living arrangements and continue to be self-sufficient. Clients mention that a major burden is relieved by the supportive services assistance provided; which allows them to focus on other aspects of their lives that require more attention. We are pleased to announce that the position of Director of Supportive Services was filed as of January 2009. A case manager was hired in the middle of February to continue providing case management services to our participants. This allowed our Supportive Services Coordinator to assist with the expansion of the food program. The Catalyst foundation has been able to provide a continuum of services under one roof. We have been able to implement the Adverse Childhood Experience (ACE) training for our staff during this quarter. Our outreach efforts have doubled, and we have been able to reach the post incarcerated clients who are obtaining services and actively working to integrate back into society.

Challenges: Due to the hard economic times that we are facing, we have noticed an increase in clients that have been laid off. We have many clients who are looking for programs that will assist with employment issues. The organizations that we refer our clients out to obtain employment services are having large case loads and are not able to obtain employments for many clients. Many restaurants and local businesses in the AV have closed and the unemployment rate is extremely high in our area. We have many parolees that have very little food and are requesting food assistance to be able to survive. We have noticed an increase in the senior population requesting assistance for food.

Action Plan: The Catalyst foundation is currently in the process of networking with other non-profit organizations to obtain referrals that will be utilized when clients are looking for employment. The Catalyst Foundation will outreach to the local EDD office and post flyers and information about the supportive services provided in order to get the word out about the assistance we offer.

Client Success Story: We had a client who suffers from renal failure. He was denied by Medi-Cal. Our case manager was able to go with him to our local DPSS office and advocate on his behalf. Case Manager and client were referred to a Social Security eligibility worker to obtain assistance with this case. After a couple of weeks advocating and providing DPSS and Social Security Administration with information on the clients medical condition. The client obtained Medi-Cal and was able to obtain some medications that were vital in his medical care. The hard work and advocacy of his case manager saved his life. The client was very happy that he was able to obtain medications that helped improve his medical condition.

25d) Homes for Life Foundation – Vanowen Apartments
Budget: $738,310 (City and Community Program)

Table D.4: Homes for Life Foundation – Vanowen Apartments
FY 2008-09, January - March 2009

(unduplicated clients)	Quarter		Quarter
Homeless Individuals	12	16-24	1
Chronic Homeless Individuals	2	25-49	13
At-risk Individuals	10	50+	10
Female	10		
Male	14		
		Housing (permanent)	24
Hispanic	2		
African American	5	Case management	24
White	13	Life skills	24
Asian/Pacific Islander	2	Mental health care	24
Other	1	Transportation	24

Level 2 case management services	
Average for each participant per month:	2 hours
Total hours for all participants:	24 hours
Number of cases per case manager:	12 cases
Number of organizations/agencies that your program has a formal collaboration for this project.	1
Number of times collaborative partners met each month.	2
Total amount ($) of HPI funding leveraged for project.	-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).	-
Number of participants who have enrolled (entered) into program during the reporting period.	24
Number of participants who left the program during this period.	0
Total number currently enrolled in program.	24
Number of clients who received an assessment (if applicable).	24
Cost per participant.	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.	24
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.	24

Successes: The building opened on March 16, 2009 and is currently fully occupied.

Challenges: Clients are currently in the process of setting up service plans to determine service needs.

Client Success Story: A client moved into Vanowen Apartments just a few weeks ago. He had been homeless until he found another organization that gave him temporary housing. Now he is delighted to have a place to call a home for life. He is showing great independence by going into the community and getting the other services he needs to live a stable life. He is eager to increase his level of recovery and we are more than happy to support him in his efforts.

25e) Hope Gardens Family Center (Union Rescue Mission)
Budget: $1,853,510

Table D.5: Hope Gardens
FY 2008-09, January - March 2009

(unduplicated count)	Qtr		Qtr
		Education	72
Homeless Families	37	Job training, referrals	17
(individuals)	111	Job placement	2
Female	70	CalWORKs	37
Male	41	Food Stamps	37
		Medi-Cal/Medicare	37
		Section 8	5
Hispanic	19	SSI/SSDI	3
African American	54	Veterans	2
White	21		
Asian/Pacific Islander	3	Case management	37
Other	14	Life skills	18
		Mental health	37
		Health care	37
15 and below	72	Social/community activity	37
16-24	2	Substance abuse treatment (outpatient)	2
25-49	34	Transportation	35
50+	2		
Moving assistance	4	Case management (level II)	
Housing (emergency)	1	Average hours per case:	10
Housing (transitional)	37	Total number of hours:	370
Housing (permanent)	2	Caseload:	12
Clients stayed an average of 707 days in temporary housing. Ten of these participants were placed into permanent housing			

Successes: During the first quarter of reporting, the program has successfully transitioned four families (10 individuals) of the six transitioning families (18 individuals) into permanent housing. This 67% rate is consistent with our 62% transition rate for families who moved into permanent housing in 2008. The transitioning families were part of the total 37 families served (111 individuals) this quarter, of which 31 families (93 individuals) are still housed at Hope Gardens. The families transitioned into the following areas:

- Five individuals (2 family units) were housed with Section 8 housing.
- Five individuals (2 family units) permanently relocated with family and friends to permanent housing.
- Five individuals (1 family unit) transitioned back into transitional housing due to being immediately relocated because of medical reasons. (Severe asthma)
- Three (individuals 1 family unit) transitioned into emergency shelter.

Challenges: There are always timeline challenges, when implementing a new program. When a program design is written we have the best intentions; however; when working to resolve various challenges in the lives of others, flexibility is essential.

During this first quarter, we have learned many things from our families. For instance, many have come through our doors exhausted from the numerous programs they have encountered where they have been unsuccessful in finding housing or long term solutions to meet their needs. Hope Gardens continues to be one of a few programs that works with large families including those with male children 10 years or older.

Hope Gardens was designed to be a comprehensive program with a wide variety of opportunities available for those wanting to break the cycle of homelessness. The challenge has been that because these hurting families are so worn out from the cycle of defeat and disappointments, we must embrace them with encouragement and the time necessary to build them back up so they are willing to take one more step in their quest for ending a cycle of generational homelessness. This is a challenge with each family, but we continue to work with our participants to identify and get beyond barriers that have kept them from achieving (and exceeding) their goals. This is the primary reason for those not being transitioned into permanent housing and completing the program.

Action Plan: Hope Gardens will continue to work through challenges that are presented either in our program design and/or with our families. We vow to consistently evaluate our services, staff and program to ensure that we are providing excellent care to the families served at Hope Gardens. This includes establishing very realistic and specific timelines and individualized service plans with each family without trying to fit them into a “one size fits all” mold that is unachievable for many families.

During this first quarterly report we will streamline our statistical database to ensure that we capture all required services and report in a timely fashion. It is our desire to increase the number of families being served until we reach our maximum capacity. We anticipate an increase in the number of families served once renovations are completed on additional buildings.

Client Success Story: A thirty-one year old single mother of a seven year old son became homeless in July of 2006. “It was approximately two years after I was honorably discharged from the U.S. Navy and about five months following the separation from my husband of five years. Flittering back and forth between options for a while and even went out of state for a period of time. The constant movement became tiresome, and I found the situation too toxic and demeaning to continue to expose my son.

Through these many experiences I learned it was better for me to attempt to depend on myself because that would be the only way for me to maintain my own self-respect and the respect of my son. I was very thankful when I found Hope Gardens, a temporary place to really call home.

Beyond housing, I am working on increasing my marketability so that we can do more than just survive; we would love to thrive. Education is definitely a priority for both me and my son. Since I’ve been at Hope Gardens, I have gone back in school to complete my A.S. in Nursing. With my degree, I can continue to grow in independence and teach my son the value of an education. Hope Gardens has been the best opportunity I have had to get my life back on track.”

25f) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
Budget: $900,000

Table D.6: Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
FY 2008-09, January - March 2009

(unduplicated count)	Qtr		Qtr
Homeless Individuals	5	Case management	16
Chronic Homeless Individuals	11	Mental health	16
		Health care	16
Female		Social/community activity	16
Male	10	Substance abuse treatment (residential)	1
	6	Transportation	16
Hispanic	3		
African American	7	Case management (level 3)	
White	6	Average hours per case:	5
		Total number of hours:	80
16-24	1	Caseload:	30
25-49	9		
50+	6	Eviction prevention	1
		Housing (emergency)	1
		One participant stayed in emergency housing for a day, and then the participant was placed into permanent housing.	

	Qtr
Number of organizations/agencies that your program has a formal collaboration for this project.	-
Number of times collaborative partners met each month.	-
Total amount ($) of HPI funding leveraged for project.	$131,116
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).	15%
Number of participants who have enrolled (entered) into program during the reporting period.	16
Number of participants who left the program during this period.	0
Total number currently enrolled in program.	16
Number of clients who received an assessment (if applicable).	16
Cost per participant.	$1,256
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.	n/a

Successes: The program has been able to meet members' basic needs, such as providing a safe place to shower, do laundry, and receive counseling, psychiatric treatment and basic medical attention. Case management and move-in assistance has allowed participants to get off the street.

Challenges: It has been a challenge to locate affordable housing, because many participants are on a limited source of income.

Action Plan: The program will continue to research and locate more affordable housing as well as build community relationships.

Client Success Story: We have a member that our outreach team was able to get off the street and into mental health treatment at a residential substance abuse treatment center. This program has made a significant improvement in his life.

25g) Skid Row Housing Trust – Skid Row Collaborative (SRC2)
Budget: $1,800,000 (City and Community Program)

Table : Skid Row Housing Trust
FY 2008-09, January - March 2009

(unduplicated count)	Qtr		Qtr
		Education	1
Chronic Homeless Individuals	85	Job training	3
		Shelter Plus Care	85
Female	26		
Male	59	Case management	79
		Mental health	36
Hispanic	7	Health care	27
African American	67	Life skills	35
Asian/Pacific Islander	18	Social/community activity	24
More than on race/ethnicity may be selected		Substance abuse treatment (outpatient)	55
		Transportation	6
16-24	1		
25-49	40	Case management (level 3)	
50+	44	Average hours per case:	9
		Total number of hours:	1,144
Rental subsidy	85	Caseload:	22
Housing (permanent)	85		

	Qtr
Number of organizations/agencies that your program has a formal collaboration for this project.	2
Number of times collaborative partners met each month.	2
Total amount ($) of HPI funding leveraged for project.	$193,747
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).	-
Number of participants who have enrolled (entered) into program during the reporting period.	85
Number of participants who left the program during this period.	0
Total number currently enrolled in program.	85
Number of clients who received an assessment (if applicable).	79
Cost per participant.	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.	100
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.	15

Successes: This program is a collaborative effort – Behavioral Health Services, JWCH Institute, and Skid Row Housing Trust are the primary service partners. Our contract was executed on February 3, 2009. We began enrolling participants on February 4, 2009. By the end of this reporting period, we enrolled 85 chronically homeless men and women with disabilities into the program (85% of our goal). In addition, we are pleased with the participants' level of engagement in the program as evidenced by our service receipt data.

Challenges: Our program design includes an extensive array of on-site services including comprehensive case management, benefits advocacy, primary medical care, psychiatric services, and substance abuse treatment. Our most significant challenge has been recruiting a Benefits Specialist and Psychiatrist. We are currently able to provide psychiatric services one afternoon a week.

Action Plan: JWCH (the partner responsible for hiring the Benefits Specialist and Psychiatrist) is aggressively recruiting for these positions and has broadened its outreach to include a larger number of advertising sites as well as personnel recruiting services. We are confident that these positions will be filled during the current quarter.

Client Success Stories: Several residents have been reported on by both the Downtown News and the LA Times for their success in making it from the streets to a home in the Abbey Apartments. Several people in the project are in housing for the first time in more than ten years and several others are only now beginning to receive medical, psychiatric and mental health treatment for long standing, debilitating

conditions. One woman in particular has diabetes and had been living on the streets for 12 years. She became ill recently. Instead of being taken to the emergency room by paramedics and then treated and released back to the streets, the funding from HHPF made it possible for her to go downstairs to the medical offices. At the medical office, she was seen by a medical provider and treated for severe dehydration. Afterwards, she was sent back to her own home one floor up to recover. This has made a huge difference for her and for the community.

25h) Southern California Alcohol and Drug Programs (SCADP), Inc. - Homeless Co-Occurring Disorders Program
Budget: $1,679,472 (City and Community Program)

Table D.7: SCADP
FY 2008-09, through March 31, 2009

(unduplicated clients)	YTD		Quarter
Homeless Individuals	84	Housing (transitional)	3
Homeless Families (individuals)	6 13	Mental health care	75
Transition age youth	5	Substance abuse treatment (residential)	75
At-risk Individuals	29		
Female	18		
Male	106		
Hispanic	73	Average length of stay for residents	70
African American	36	Residents discharged due to graduation	40
White	24	Discharge status for residents of transfer	5
Native American	3	Discharge status for residents of walk-out	15
		Discharge status for residents, violated rules	10
15 and under	7		
16-24	15		
25-49	96		
50+	9		

Number of participants who have enrolled (entered) into program during the reporting period.	60
Number of participants who left the program during this period.	75
Total number currently enrolled in program.	40
Number of clients who received an assessment (if applicable).	50
Cost per participant	$1,000
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter.	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter.	-

Successes: We are progressing in our service implementation. In the upcoming months, we hope to expand our services to the needed level for this clientele.

Challenges: At this point, the non-service provision requirements of the grant still need improvement in order for services to be efficiently provided.

Action Plan: The project director will have more time to spend on this project as another project nears completion. The additional time is expected to have a positive impact on this project.

Client Success Story: At this point, none have remained in one of the residential programs where the services are offered for a six month period. Four of the participants that enrolled in November are attending college and working.

25i) Volunteers of America - Los Angeles, Strengthening Families
Budget: $1,000,000 (City and Community Program)

Table D.8: VOALA
FY 2008-09, through March 31, 2009

(unduplicated clients)	YTD		YTD
Homeless Families	49	Alternative court	2
(individuals)	223	Case management	96
At-risk Families	43	Life skills	43
(individuals)	185	Mental health	16
		Health care	17
Female	222	Social/community activity	21
Male	186	Substance abuse treatment (outpt.)	2
		Transportation	43
Hispanic	408	Food pantry	2
15 and below	166	Medi-Cal/Medicare	69
16-24	67	CalWORKs	11
25-49	106	General Relief w/Food Stamps	14
50+	11	General Relief only	1
		Shelter Plus Care	1
Eviction prevention	6	SSI/SSDI	6
Moving assistance	14	Food Stamps only	28
Housing (emergency)	7	Section 8	2
Housing (transitional)	4		
Housing (permanent)	4	Education	26
Rental subsidy	2	Job training, referrals	43
		Job placement	16

Average stay at emergency/transitional housing:	30 days
Number placed into permanent housing:	2 families
Level 1 Case management	
Average case management hours for each participant per month:	5
Total case management hours for all participants during current reporting period:	1,205 hours
Number of cases per case manager:	20 cases

Longer-term Outcomes (Six months or more)	
Maintained permanent housing (through eviction prevention, linkages to jobs)	55
Receiving rental subsidy	2
Obtained employment	5
Maintained employment	12
Enrolled in educational program, school	6
Received High School Diploma/GED	1
Case management	112
Health care	33
Good or improved physical health	2

Number of organizations/agencies that your program has a formal collaboration for this project.	5
Number of times collaborative partners met each month.	4
Total amount($) of HPI funding leveraged for project.	$1,000,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).	50%
Number of participants who have enrolled (entered) into program during the reporting period.	84
Number of participants who left the program during this period.	1
Total number currently enrolled in program.	81
Number of clients who received an assessment (if applicable).	81
Cost per participant.	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter.	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter.	-

Successes: During this reporting period, the Strengthening Family Case Managers assisted a total of 81 families in finding and obtaining affordable, temporary and transitional housing. Also, they assisted families in finding employment by taking them to career fairs, assisting with their resumes, and building other job readiness skills.

Challenges: Some challenges that case managers encountered during this reporting period included the lack of affordable housing for low income families, families, and members who have disabilities. Additionally, many families did not qualify for conventional housing programs due to their income or family size (specifically number of children).

Action Plan: The program plans to continue providing effective case management for families and seek community collaborative in order to assist families effectively. Additionally establish and implement workshops that assist families with housing, employment, finance and other needed services.

Client Success Story: Through effective, compassionate and culturally sensitive case management, the case workers have been able to assist families in finding affordable housing by collaborating with other community agencies. By sharing resources, the program has been able to take participants to career fairs, strengthen their job readiness skills, and prevent evictions by providing rental subsidies and other needed services.

25j) Women's and Children's Crisis Shelter
Budget: $300,000 (City and Community Program)

Table D.9: Women's and Children's Crisis Center
FY 2008-09, through March 31, 2009

(unduplicated clients)	YTD		YTD
Homeless Families	38	15 and below	69
(individuals)	107	16-24	61
At-Risk Individuals	322	25-49	175
		50+	12
Female	385		
Male	44	Housing (emergency)	81
		Housing (transitional)	4
Hispanic	237	Average stay	30 days
African American	78	Number to shared living w/friends or family	35
White	27		
Asian/Pacific Islander	10	Life skills	14
Native American	-	Mental health care	33
Other	77	Transportation	46

Program Specific Measures	Quarter
Number of hotline calls that are related to domestic violence issues.	271
Number of hotline calls that are related to homeless issues.	58
Of the calls related to domestic violence, the number of families/individuals at-risk of becoming homeless.	194
Number of individuals reunited with their families.	-
Number of participants who have enrolled (entered) into program during the reporting period.	24
Number of participants who left the program during this period.	15
Total number currently enrolled in program.	7
Number of clients who received an assessment (if applicable).	-
Cost per participant.	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter.	2
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter.	6

Successes: By the end of March 2009, four CDC families continued to reside in the emergency shelter. Two families now had restraining orders and two were pending. They have all successfully participated in the program.

Challenges: Three CDC families exited the shelter and moved to their friends' and/or parents' homes. These families had difficulty with the safety restrictions of the emergency shelter program.

Action Plan: For the next month, our therapists will work specifically towards helping each client adapt more easily to the restrictive environment of the emergency shelter.

Client Success Story: One family exited to a relative's home with a restraining order in place. The mother decided to work. She is linked to a legal non-profit that continues to help her with custody issues.

VI. COUNCIL OF GOVERNMENTS (COGs)

26a) San Gabriel Valley Council of Governments
Budget: $200,000 (On-going)

In April 2009, a study team consisting of the Corporation for Supportive Housing, Shelter Partnership, Inc., Urban Initiatives, and McDermott Consulting, presented the San Gabriel Valley Regional Homeless Services Strategy Final Report to the San Gabriel Valley Council of Governments (SGVCOG). The final report included a summary of priorities presented by sub-regional cluster group and the following key issues were identified.

- First Priority: Permanent Supportive Housing
- Second Priority: Short-Term Housing (Emergency Shelter & Transitional Housing)
- Third Priority: Access Center

Implementation Strategy and Recommendations
A summary of five-year housing and service targets was presented by cluster group. Overall for the region, three strategic objectives, related recommendations, and a timeline were presented.

Strategic Objective I: Develop Leadership, Political Will, and Community Support

- Recommendation 1: Create a Valley-wide Membership Based Organization for the Primary Purpose of Education, Advocacy, and Coordination
- Recommendation 2: Meet and Confer with Municipal Leaders, Community Groups, Business Leaders, Faith-based and Community Service Providers within the San Gabriel Valley

Strategic Objective II: Build Provider Capacity and Expand the Service Delivery System

- Recommendation 1: Engage Community and Faith-based Service Providers in Planning, Training and Overall Capacity Building
- Recommendation 2: Create More Housing Opportunities for Homeless Persons in the San Gabriel Valley
  - √ 588 units of permanent supportive housing over the next five years
  - √ 150 emergency shelter beds and 300 transitional housing beds for single individuals over the next five years
  - √ Scattered-site housing programs to serve 100 families annually
- Recommendation 3: Create an Access Center in Cluster Five (Claremont, Diamond Bar, Glendora, La Verne, Pomona, and San Dimas)
- Recommendation 4: Develop Valley-wide Referral and Information Sharing System

Strategic Objective III: Leverage and Maximize Utilization of Available Financial Resources

- Recommendation 1: Form a San Gabriel Valley Supportive Housing Pipeline Review Committee
- Recommendation 2: Commit Local Investments from Municipalities Across Multiple Jurisdictions within the San Gabriel Valley to Stimulate Housing Production
- Recommendation 3: Utilize New Funding Opportunities to Expand Short-term Housing and Rapid Re-housing Programs

26b) PATH Partners/Gateway Cities Homeless Strategy
Budget: $135,000 (On-going)

PATH Partners presented the Gateway Cities Homeless Strategy to the Gateway Cities Council of Governments (GCCOG). The first three categories (LEAD, ENGAGE and COLLABORATE) provide recommended actions that will build the leadership and infrastructure required to plan, develop and successfully start up the proposed programs and services presented in the IMPLEMENTATION category of the strategy.

The LEAD phase includes identification of a current or new regional leadership entity as well as designating a “Homeless Liaison” for each city. The ENGAGE phase involves formation of a stakeholder

regional homeless alliance, implementation of “connections” strategies to engage the community, and development of a public education campaign. Third, the COLLABORATE category focuses on enhanced government-wide collaboration. Specific strategies include: leveraging $1.2 million of County HPI funds to secure matching dollars within the region, exploring opportunities to secure funding from the American Recovery and Reinvestment Act of 2009, and organizing and coordinating the GCCOG cities to apply for additional funding; and coordinating a region-wide, multi-sector homeless collaborative event that integrates services and resources across agencies and departments, including government departments, service providers, faith groups and the business community. One example of an effective event that has produced demonstrated results in several communities are “homeless connect days.” The County of Los Angeles currently sponsors events that brings together hundreds of volunteers to engage homeless people and connect them to needed services all on one day.

The IMPLEMENT phase consists of four categories of implementation actions that are proposed as part of the Gateway Cities Homeless Strategy, which are all very closely intertwined and form a mini-“homeless strategy” in a region that effectively assists homeless individuals and families to move from the streets into housing and long-term independence –

√ **Homeless Prevention Services**: The region will create a minimum of two new homeless prevention programs over the next 12 months to provide prevention services to the homeless. A target goal is to have a total of four programs formed (one in each of the four group areas of the GCCOG region), over the next 3-5 years to provide accessible prevention services to those in need. Each homeless prevention program will serve 500 unduplicated individuals annually, providing screening and assessments, prevention programs and housing assistance.

√ **First Responders Program**: Geographic-based street outreach team(s) would serve as “first responders” and coordinate with local law enforcement, service providers, hospitals, businesses and others. Teams would be comprised of staff and/or volunteers, and would be multiPATH Partners 2009 disciplinary, utilizing staff from existing mental health providers, substance abuse treatment providers, county agencies, and faith groups. The GCCOG region will create a minimum of two new outreach teams over the next 12 months to provide outreach services to the Gateway Cities. A target goal is to have a total of four teams operating (one in each of the four group areas of the GCCOG) over the next 3-5 years to provide more accessible outreach services. Each outreach team will engage 80 new unduplicated homeless individuals and assist them in connecting to services annually.

√ **Interim Housing**: Develop a strategy to “rapidly re-house” individuals into interim housing, with the end goal of long-term housing. This approach will be linked to street outreach teams and will focus on intensive housing and placement assistance upon entry into interim housing, and will include linkages to housing subsidies, rental assistance programs and other supportive services. Cities/communities would place special emphasis on connecting existing interim beds and programs to street outreach, homeless prevention services, permanent supportive housing and other supportive services. The region will create a minimum of two new interim housing programs (30-40 beds per program) over the next 12 months. A target goal is to have four new interim housing programs (one in each of the four group areas in the region) over the next 3-5 years to provide housing. Each new program will serve 100 unduplicated homeless individuals annually, providing them with housing, case management and assistance in connecting to long-term housing opportunities and supportive services.

√ **Permanent Supportive Housing (PSH)**: Create a multi-year plan to increase the stock of PSH units in the GCCOG region. A proposed goal for the region is to invest in the creation of 665 units of PSH over the next five years (2010 to 2014). The production goal of 665 new units will double the number of available supportive housing units. The goal is based on an assessment of the available funding resources the GCCOG will be able to realistically access to support the creation of new PSH units. The breakdown of the 665 unit production goal over five-years includes: one 40 unit development, 175 units of smaller PSH projects and set aside units, and 450 scattered-site leasing units. A plan will be developed for acquiring further rental vouchers and/or creating more subsidized housing in the region for homeless families and single adults who do not require supportive housing but do require affordable housing in order to end their homelessness as they transition out of interim housing.

27) Los Angeles Homeless Services Authority (LAHSA) Contracted Programs

Goal: Emergency shelter and transitional housing are provided to families and individuals.
Budget: $1,735,000 (One-Time Funding)

Of these nine programs, seven program will have ended as of March 15, 2009; and two programs will end on June 30, 2011.

Table E.2: LAHSA Participants and Services

(unduplicated clients)	FY 2007-08	FY 2008-09	Total		FY 2007-08	FY 2008-09	Total
Homeless Families	483	246	729	Adult**	6,064	1,512	7,576
Homeless Individuals	3,162	890	4,052	Child	1,029	375	1,404
Chronic Homeless	2,206	336	2,542				
Female	1,938	434	2,372	Emergency housing	5,869	1.435	7,304
Male	3,931	987	4,918	Transitional housing	-	63	63
Hispanic*	1,385	596	1,981				
African American	2,838	563	3,401				
White	2,004	1,075	3,079				
Asian/Pacific Islander	151	76	227				
Native American	168	110	278				
Other	1,598	48	1,646				

*LAHSA uses the federal definition of Hispanic origin (which for the Feds includes all Spanish speaking nations in the Americas and Spain). There are two options: Hispanic or Non-Hispanic.

**The U. S. Department of Housing and Urban Development (HUD)defines an adult as a person 18 years of age or older. LAHSA uses the HUD definition of adult in its data collection process.

28) PATH Achieve Glendale

Budget: $150,000 (One-Time Funding)

Table E.3: PATH Achieve Glendale
FY 2008-09, January – March 2009

(unduplicated clients)	YTD		YTD
Homeless Individuals	253	15 and below	148
Chronic Homeless	79	16-24	89
Homeless Families	213	25-49	379
(Individuals)	434	50+	150
Female	418	Housing (emergency)	86
Male	348	Housing (transitional)	29
		Housing (permanent)	32
Hispanic	206		
African American	332	Case management	545
White	212		
Asian/Pacific Islander	9		
Native American	7		

** Transitional and permanent housing placement was estimated based on the ratio of transitional to permanent housing placements indicated in HMIS reports. The total number of placements (61 residents) was verified by an Emergency Housing Program report.*

Successes: Access Center case managers served 545 adults experiencing homelessness during the reporting period. Some were living on the streets of Los Angeles County, others in a variety of shelter or housing programs. Of these participants, 86 women, men, girls and boys were admitted into the 60-90 day Emergency Housing Program at PATH Achieve Glendale (PAG). Fifty-four percent of the households in Emergency Housing saved at least $500. Fifty-three percent increased their life skills by accessing at least two supportive services. Of those who exited the shelter program, 73% were placed in permanent or transitional housing.

Challenges: PATH Achieve Glendale staff and managers have been working with City of Glendale administrators of the Homeless Management Information System (HMIS) to perfect the data and work bugs out of the system; however, there are still barriers to getting reliable reports based on the entered data.

Also, there is the ongoing challenge of placing local chronically homeless from the street into housing.

Action Plan: More regular meetings between PAG and City staff have been scheduled to address lingering issues and structure is being developed for documenting issues as they are identified.

A team is being assembled across disciplines and agencies to address the special needs of the most vulnerable on the street in Glendale in time to take advantage of five new Shelter + Care units.

Client Success Story: (Letter from a client) “When I came to PATH Achieve Glendale in March 2009, I was frightened and didn’t know what to expect, being this was the first time I’ve been without a home. Tears were flowing and I couldn’t stop them. Then I heard that PATH Achieve Glendale has a stress management class on Wednesday mornings. I went the next Wednesday and really enjoyed how the social worker taught her class so I made an appointment the same day for an individual eye movement desensitization and reprocessing (EMDR) appointment. Within two weeks the tears stopped flowing. I cannot tell you how much the social worker has helped me, she brought me through some painful things I shared. Her training skills really work and I use them today when I’m going through difficult situations. She has been a blessing to me. She’s very kind and easy to talk to. I thank God that PATH Achieve has such a wonderful program.”

A 74-year-old client has been working diligently with her case manager to meet her goals, including establishment of savings from her Social Security income, obtainment of necessary medical care for a chronic respiratory condition, and application for affordable housing. The client’s application for subsidized housing has been accepted at a lovely building for seniors in the San Fernando Valley. She plans to move into her new apartment by July 1, 2009.